Supreme Court, U.S.
FILED

98 1836 MAY 13 1999

OFFICE OF THE CLERK

No. _____

In The

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

PETITION FOR A WRIT OF CERTIORARI

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

9188

QUESTION PRESENTED

Petitioner is a health maintenance organization that administers an "employee benefit plan" within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a). Petitioner was sued in a third-party complaint in a negligence action because, when the subscriber's treating physician sought pre-authorization from petitioner to transfer the subscriber to a particular hospital, petitioner declined to provide that authorization. The sole basis for that refusal was that the proposed transferee hospital did not participate in petitioner's HMO network. Instead, petitioner advised the physician that the subscriber could be transferred to any of three other hospitals in the area that were participants in petitioner's network. The Pennsylvania Supreme Court broadly held that state law "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," and are therefore not preempted by Section 514(a) of ERISA. The question presented is:

> Does Section 514(a) of ERISA preempt state law claims arising from a health maintenance organization's alleged negligence in its administration of benefits under an ERISA-governed health plan?

RULE 14.1(b) and 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner United States Healthcare Systems of Pennsylvania, Inc., states that the other parties to this action are Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund. Basile Pappas and Theodora Pappas were plaintiffs in the trial court, but their claims against defendants Dr. David S. Asbel and Haverford Community Hospital were settled. App. 45a-46a. As a result of the settlement, Mr. and Mrs. Pappas and Dr. Asbel are no longer parties to this litigation. Subsequent to the settlement, respondents Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund, who were the insurers for defendant Haverford Community Hospital, were substituted as the real parties in interest for the Hospital. App. 45a-46a.

Pursuant to Rule 29.6, petitioner states that the parent companies of United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") are Aetna U.S. Healthcare, Inc. and, ultimately, Aetna, Inc. U.S. Healthcare does business as the Health Maintenance Organization of Pennsylvania; it has no subsidiaries.

TABLE OF CONTENTS

Page

Question Presented i

Rule 14.1(b) and 29.6 Statement ii

Table of Authorities iv

Opinions Below 1

Jurisdiction 1

Constitutional and Statutory Provisions Involved ... 2

Statement 2

A. Factual Background 2

B. Procedural History 5

Reasons for Granting the Petition 7

I. The Decision Below Conflicts With This Court's Decisions Construing Section 514(a) of ERISA 7

II. The Decision Below Conflicts with Decisions By The Third Circuit and Numerous Other Courts of Appeals Throughout The Country 13

III. This Court's Review is Needed to Bring Coherence To An Important Area of Law That Has Caused Confusion In The Lower Courts 19

Conclusion 22

TABLE OF AUTHORITIES

Page

CASES

Baldwin v. Alabama, 472 U.S. 372 (1985)..... 13

Bast v. Prudential Insurance Co. of America, 150 F.3d 1003 (9th Cir. 1998).....15, 18

California Division of Labor Standards Enforcement v. Dillingham Construction, 519 U.S. 316 (1997) 6, 9

Cannon v. Group Health Service, 77 F.3d 1270 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996).....15, 18

Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992)..... 16

Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975) 1

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997).....6, 9, 10, 19

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995) 13, 14

Engelhardt v. Paul Revere Life Insurance Co., 139 F.3d 1346 (11th Cir. 1998)..... 16

Hohn v. United States, 524 U.S. 236, 118 S. Ct. 1969 (1998) 11

Huss v. Green Spring Health Services, Inc., No. 98-6055, 1999 U.S. Dist. LEXIS 5101 (E.D. Pa. April 16, 1999) 14

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996)..... 16

Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994).....16, 18

Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985) 6, 8, 9, 10, 11

TABLE OF AUTHORITIES – Continued

Page

New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995) ..... *passim*

Painter v. Golden Rule Insurance Co., 121 F.3d 436 (8th Cir. 1997), *cert. denied*, 118 S.Ct. 1516 (1998) 16

Parrino v. FHP, Inc., 146 F.3d 699 (9th Cir.), *cert. denied*, 119 S.Ct. 510 (1998) 16, 18

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) ..... *passim*

Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995)..... 14

Rodriguez de Quijas v. Shearson/American Express, Inc., 490 U.S. 477 (1989) 11, 12

Settles v. Golden Rule Insurance Co., 927 F.2d 505 (10th Cir. 1991)..... 17

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 6, 8, 9, 10, 11

Spain v. Aetna Life Insurance Co., 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994) 17, 18

Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995) 17

Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196 (1st Cir. 1997), *cert. denied.*, 118 S.Ct. 1512 (1998)..... 15

UNUM Life Insurance Co. of America v. Ward, ___ U.S. ___, 67 U.S.L.W. 4243 (April 20, 1999)..... 10, 11, 19

United States v. International Business Machines Corp., 517 U.S. 843 (1996)..... 12

Yee v. Escondido, 503 U.S. 519 (1992)..... 13

TABLE OF AUTHORITIES – Continued

Page

STATUTES AND REGULATIONS

28 U.S.C. § 1257 1

Section 502(a) of Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a) 13, 14

Section 514(a) of Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a) ..... *passim*

42 U.S.C. § 300e 9

28 Pa. Code § 9.75 9

MISCELLANEOUS

R. Charrow and L. Greenlees, "ERISA Pre-emption – A Law in Search of a Doctrine," 27 Health Law Digest No. 3 (March, 1999) 20

P. Jacobson and S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Hous.L.Rev. 985 (1998) 21

K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. on Reg. 255 (1996) 21

Note, *You Can't Get There From Here – Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 Ga.L.Rev. 1023 (1996) 21

B. Richardson, *Health Care: ERISA Preemption and HMO Liability – A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 Okla.L.Rev. 677 (1996) 20

PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the Pennsylvania Supreme Court in this case.

OPINIONS BELOW

The opinion of the Pennsylvania Supreme Court is reported at 724 A.2d 889. App. la-16a. The opinion of the Pennsylvania Superior Court reinstating the third-party complaint by Defendant Haverford Community Hospital against petitioner is reported at 450 Pa. Super. 162, 675 A.2d 711 (1996). App. 20a-33a. The opinion of the Court of Common Pleas of Delaware County granting petitioner's motion for summary judgment on the third-party complaint is unreported. App. 34a-44a.

JURISDICTION

The Pennsylvania Supreme Court rendered its decision on December 23, 1998, and denied petitioner's Application for Reargument on February 12, 1999. App. 2a, 62a. This Court's jurisdiction is invoked under 28 U.S.C. § 1257. *See Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 482-483 (1975).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., art. VI, cl.2.

Section 514(a) of ERISA states that "the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . " 29 U.S.C. § 1144(a).

STATEMENT

A. Factual Background

Basile Pappas was a subscriber of the Health Maintenance Organization of Pennsylvania ("HMO Pa.")[1] through an employee welfare benefit plan provided to his wife by her employer. App. 35a-36a. HMO Pa. administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

[1] HMO Pa. is a subsidiary of petitioner. App. 36a.

On May 20, 1991, Mr. Pappas went to his primary-care physician, Dr. David Asbel, complaining of neck and shoulder pain. App. 48a. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of steroids. *Id.* The next morning, Mr. Pappas was unable to walk and was experiencing numbness in his extremities. App. 49a. He was transported by ambulance to Haverford Community Hospital ("Haverford"). *Id.* The emergency room physician at Haverford, Dr. Steven Dickter, concluded that Mr. Pappas was suffering from an epidural abscess which pressed upon his spinal column. App. 36a. Dr. Dickter concluded that Mr. Pappas should be treated at a "university" hospital, which would have more extensive facilities than Haverford. *Id.*

Dr. Dickter decided to transfer Mr. Pappas to Jefferson University Hospital ("Jefferson"). *Id.* When the ambulance arrived at Haverford at 12:40 p.m. to pick up Mr. Pappas, Dr. Dickter was informed by the ambulance personnel that Jefferson was not an HMO Pa. participating hospital, meaning that it was not one of the hospitals with which HMO Pa. contracts to provide hospital services to its plan members. App. 21a, 36a. At 12:50 p.m., Dr. Dickter telephoned HMO Pa. to inquire as to Jefferson's status with HMO Pa. *Id.* Within fifteen minutes, HMO Pa. advised Dr. Dickter that coverage would not be provided for treatment at Jefferson, since it was not a participant in HMO Pa.'s network, but that there were three HMO Pa. participating hospitals in the vicinity (Temple University, Hahnemann University ("Hahnemann") and Medical College of Pennsylvania) to which Mr. Pappas could be transferred. App. 21a, 36a. No allegation has been made that these three hospitals were

inferior to Jefferson, or that they were not appropriately equipped and staffed to treat Mr. Pappas' medical condition.

Thereafter, Dr. Dickter of Haverford called Dr. Asbel, Mr. Pappas' primary physician, to ascertain Dr. Asbel's preference concerning his patient's destination. App. 36a. Dr. Asbel expressed a preference for Hahnemann, but Hahnemann delayed in responding to Dr. Dickter's inquiry concerning its intensive care unit bed space availability. App. 37a. At approximately 2:20 p.m., Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before Hahnemann could determine whether it had bed space for Mr. Pappas. *Id.* As a result of Hahnemann's delays, Dr. Dickter then called Medical College of Pennsylvania, where Mr. Pappas was transported. *Id.*

Mr. Pappas and his wife brought a medical malpractice action against Dr. Asbel and Haverford, alleging that their delay in transferring Mr. Pappas to a hospital capable of treating his condition caused his spinal cord compression to continue and led to quadriplegia. App. 47a-58a. Mr. and Mrs. Pappas did not sue petitioner. Haverford then filed a third-party complaint for contribution and indemnification against petitioner, complaining that "HMO-PA refused to authorize transfer of [Mr. Pappas] to a hospital selected by physicians at Haverford Community Hospital," namely, Jefferson. App. 60a. Haverford also incorporated the allegation in the Pappas' Complaint that there was an inordinate delay in transferring Mr. Pappas from Haverford to a more suitable hospital. *Id.* The sole basis for petitioner's alleged liability to Haverford was petitioner's administrative decision to

refuse coverage for treatment at Jefferson because it was a non-participating hospital.

B. Procedural History

Petitioner moved for summary judgment on the third-party complaint by Haverford on the grounds that all of Haverford's claims were preempted by Section 514(a) of ERISA. The trial court granted that motion, stating that Haverford's allegations against petitioner "fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision." App. 41a. The court further stated as follows: "Haverford Hospital seems to suggest that [petitioner] is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under [petitioner's] programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan." App. 43a.

The plaintiffs' claims against Dr. Asbel and Haverford were settled, and thereafter the trial court entered an order substituting Haverford's insurers, Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund"), for Haverford as the real parties in interest. App. 45a-46a.

PHICO and the CAT fund appealed the summary judgment order to the Pennsylvania Superior Court, which reversed the trial court and found no preemption

of Haverford's claims against petitioner under Section 514(a) of ERISA. App. 18a-33a. According to the Superior Court, "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's" are not encompassed within the preemptive ambit of Section 514(a) of ERISA. App. 27a.

The Pennsylvania Supreme Court, although disagreeing with the reasoning of the Superior Court, affirmed its decision that Haverford's claims against petitioner were not preempted by Section 514(a) of ERISA. App. 1a-16a. The Pennsylvania Supreme Court acknowledged that this Court gave a "deliberately expansive" interpretation to the preemption provision in Section 514(a) of ERISA in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). App. 6a-7a. However, the Pennsylvania Supreme Court expressly declined to follow those decisions, asserting that they were overruled *sub silentio* in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997). App. 7a-11a.

In a sweeping pronouncement that it did not confine to the particular facts of this case, the Court stated that "[b]ased upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App. 11a. The Court did not draw any distinction between negligence claims arising from an HMO's administration of plan benefits, such as the instant case,

and negligence claims based on an HMO's purported vicarious liability for providers' malpractice. Instead, the Court's broad holding appears to preclude an HMO from invoking the preemption provision of Section 514(a) under any set of circumstances where it has been sued for negligence.[2]

REASONS FOR GRANTING THE PETITION

I. The Decision Below Conflicts With This Court's Decisions Construing Section 514(a) of ERISA

The third-party complaint by Haverford against petitioner challenges a straightforward and commonplace ERISA plan benefits determination: coverage would be provided to Mr. Pappas if he was transferred to any of three specified hospitals that had contracted with petitioner to provide hospital services to plan members, but would not be provided if he was transferred to Jefferson, which had no such contractual relationship with petitioner. Since Haverford's negligence claim against petitioner arises from and directly relates to the administration of benefits under the ERISA-governed health plan, it falls squarely within the preemptive scope of Section 514(a) of ERISA.

---

[2] The broad sweep of the Court's ruling is further reflected in its statement that the issue it was resolving was "whether negligence claims against a health maintenance organization 'relate to' an ERISA plan." App. 6a. The factual circumstances giving rise to the negligence claim appear not to make any difference to the Court's conclusion that any such claim is not preempted.

The Pennsylvania Supreme Court's decision directly conflicts with this Court's decision in *Pilot Life*. In *Pilot Life*, plaintiff had alleged that an insurance company engaged in the processing and review of claims for benefits under an employee benefit plan had acted tortiously when it terminated his disability benefits. Relying on *Metropolitan Life* and *Shaw*, this Court emphasized the "expansive sweep of the pre-emption clause" in Section 514(a) of ERISA. 481 U.S. at 47. The Court noted that the legislative history of ERISA reflects "both the breadth and importance of the pre-emption provisions." *Id.* at 46. The Court held that "[t]he common law causes of action raised in Dedeaux's complaint, each *based on alleged improper processing of a claim for benefits under an employee benefit plan*, undoubtedly meet the criteria for pre-emption under § 514(a)." *Id.* at 48 (emphasis added).

The Pennsylvania Supreme Court's decision also conflicts with this Court's decisions in *Metropolitan Life* and *Shaw*. In both of those cases, this Court held that ERISA preempts state laws that require an ERISA-governed plan to provide certain types of coverage, because such a requirement "bears indirectly but substantially on all insured benefit plans . . . " *Metropolitan Life*, 471 U.S. at 739. The Pennsylvania Supreme Court's ruling subjects petitioner and other health maintenance organizations to tort liability for failing to authorize a member's treatment at a non-participating hospital. In essence, the decision imposes a substantive coverage requirement on ERISA-governed health plans: either permit a member to be admitted to whatever hospital the treating physician selects – regardless of whether that hospital participates in the health maintenance organization's network – or

face liability in tort for damages. Such a result cannot be reconciled with this Court's decisions in *Metropolitan Life* and *Shaw*. Moreover, it would wreak havoc on the federal and state HMO laws requiring plans to establish networks of participating providers. *See* 42 U.S.C. § 300e; 28 Pa. Code § 9.75.

The Pennsylvania Supreme Court tacitly acknowledged that the third-party complaint against petitioner would be preempted under *Pilot Life*, *Shaw* and *Metropolitan Life*, but it expressly declined to follow those decisions, characterizing them as "superannuated." App. 9a. Instead, it took the view that this Court "noticeably changed tack" in *Travelers* by adopting a "new position on ERISA preemption," and it further opined that "*Travelers* and its progeny [*Dillingham* and *DeBuono*] have thrown the expansive holdings of those earlier cases into question." App. 7a, 9a, 10a-11a. The Pennsylvania Supreme Court relied very heavily on the concurring opinion in *Dillingham* by Justice Scalia (joined by Justice Ginsburg), and it asserted that Justice Scalia had "reproached the Court for not forthrightly acknowledging that the holdings of these older cases 'have in effect been abandoned.' " App. 9a. However, the Pennsylvania Supreme Court truncated its quotation of Justice Scalia's comment, deleting the earlier part of his sentence in which he noted that the Court's opinion in *Dillingham* "does obeisance to all our prior cases." 519 U.S. at 335. Justice Scalia also stated in his concurring opinion in *Dillingham* that the majority opinion "is a fair description of our prior case law, and a fair application of the more recent of that case law" (*id.*), thereby acknowledging that *Pilot Life* remained good law.

Similarly, contrary to the Pennsylvania Supreme Court's erroneous belief, this Court's decision in *Travelers* did not overrule *Pilot Life, Shaw* or *Metropolitan Life*, either expressly or by implication. To the contrary, the *Travelers* opinion concludes by expressing "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. The continuing vitality of *Pilot Life* and *Metropolitan Life* was most recently evidenced by this Court's decision in *UNUM Life Ins. Co. of America v. Ward*, ___ U.S. ___, 67 U.S.L.W. 4243 (April 20, 1999).

In addition to *Travelers*, the Pennsylvania Supreme Court relied on *DeBuono v. NYSA-ILA Medical and Clinical Serv. Fund*, 520 U.S. 806 (1997) in support of its contention that this Court's earlier decisions in *Pilot Life, Shaw* and *Metropolitan Life* had been tacitly overruled. However, in *DeBuono*, this Court emphasized that these cases were *not* overruled, saying that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' . . . ERISA benefit plans." *Id.* at 813. Here, too, it is not necessary to rely on an expansive interpretation of "relate to" in order to find preemption, because the negligence claim at issue arises directly from the petitioner's administration of benefits under the plan. Allegations that petitioner should have pre-approved Mr. Pappas' admission at a non-participating hospital and that it delayed unduly in advising the treating physician as to the participating hospitals to which Mr. Pappas could be transferred have a clear and direct "connection with or reference to" Mr. Pappas' benefit plan, and thus are preempted.

Travelers involved a state law having only a peripheral connection with ERISA benefit plans; significantly, the Court contrasted the statute before it with earlier cases where "ERISA pre-empted state laws that mandated employee benefit structures or their administration." 514 U.S. at 658. *Accord UNUM Life Ins. Co. of America v. Ward*, 67 U.S.L.W. at 4249 (a California rule deeming the employer the agent of the insurer "would have a marked effect on plan administration," and thus "relate[s] to" an ERISA plan under Section 514(a)). Here, subjecting petitioner to potential liability in tort on account of its refusal to pre-authorize a subscriber's admission to a non-participating hospital is tantamount to "mandat[ing] employee benefit structures or their administration," and thus is preempted by Section 514(a) of ERISA.

Moreover, the Pennsylvania Supreme Court was not free to disregard *Pilot Life*, *Shaw* and *Metropolitan Life* simply because it believed them to be "superannuated." App. 9a. This Court has admonished lower courts not to anticipate the overruling of its precedents, stating that "[o]ur decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn v. United States*, 524 U.S. 236, 118 S.Ct. 1969, 1978 (1998). *Accord Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989) ("[i]f a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower court] should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.").

The pernicious effect of anticipatory overrulings of this Court's precedents by lower courts is not merely that it usurps this Court's unique prerogative. Such overrulings – unless corrected by this Court – also force litigants to proceed under a view of the law that may very well prove to be wrong. For example, in *United States v. International Business Machines Corp.*, 517 U.S. 843 (1996), the lower court was of the view that one of this Court's Export Clause precedents might have been superseded by later precedents. Had the court of appeals done what the Pennsylvania Supreme Court did in this case, IBM would have had a substantial tax liability to the federal government, yet this Court ultimately concluded (by a 6-2 vote) that the questioned precedent was not an "anachronism in need of modernization," *id.* at 850, and IBM prevailed. *See also Rodriguez de Quijas*, 490 U.S. at 486 (Stevens, J., joined by Brennan, Marshall & Blackmun, JJ., dissenting) (criticizing as "an indefensible brand of judicial activism" the lower court's failure to follow a Supreme Court precedent thought to have been superseded by later decisions). This Court should not sit idly by while the Pennsylvania Supreme Court reaches conclusions that directly contradict un-overruled decisions of this Court, and are also wrong.

The Pennsylvania Supreme Court's unprecedented holding that any and all negligence actions against health maintenance organizations do not "relate to" an ERISA plan stands in direct conflict with this Court's decision in *Pilot Life*, where this Court held that Section 514(a) preempts suits alleging improper processing of a claim for benefits. A cause of action predicated on a health maintenance organization's alleged negligence in administering

benefits under an ERISA-governed plan plainly "relates to" the plan, and is therefore preempted under Section 514(a) of ERISA.

II. The Decision Below Conflicts With Decisions By The Third Circuit And Numerous Other Courts of Appeals Throughout The Country

Conspicuous by its absence from the decision below is the citation of *any* case from any court that supports the Pennsylvania Supreme Court's sweeping pronouncement that all negligence claims against health maintenance organizations fall outside the preemptive scope of Section 514(a). Indeed, the Pennsylvania Supreme Court did not and could not cite any cases to support its unprecedented holding, because none exists.

The Pennsylvania Supreme Court's ruling conflicts with the Third Circuit's decision in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), *cert. denied*, 516 U.S. 1009 (1995), creating an unseemly split between the state and federal courts in Pennsylvania in construing Section 514(a) of ERISA. Resolution of this conflict is necessary to prevent forum shopping. *See Yee v. Escondido*, 503 U.S. 519, 538 (1992) (granting certiorari to resolve conflict between Ninth Circuit and California state courts, this Court noted that "[f]orum shopping is thus of particular concern"); *Baldwin v. Alabama*, 472 U.S. 372, 374 (1985) (granting certiorari to resolve conflict between Eleventh Circuit and Supreme Court of Alabama).

In *Dukes*, the Third Circuit held that Section 502(a) of ERISA completely preempts claims based on utilization review decisions and other plan benefit determinations,

but does not completely preempt claims challenging the quality of care a subscriber receives.[3] The Pennsylvania Supreme Court's declaration that *all* negligence claims against a health maintenance organization are outside the preemptive scope of Section 514(a), even if they relate to the administration of benefits under a plan, is in direct conflict with *Dukes*. *See Huss v. Green Spring Health Services, Inc.*, No. 98-6055, 1999 U.S. Dist. LEXIS 5101 at *13 (E.D. Pa. April 16, 1999) (noting the "tension" between *Dukes* and the Pennsylvania Supreme Court's decision in this case and following *Dukes*). Remarkably, the Pennsylvania Supreme Court's opinion made absolutely no mention of *Dukes*; it simply ignored the suggestion by Justice Nigro in his concurring opinion to adopt the rationale of the *Dukes* decision.[4] App. 16a.

The Pennsylvania Supreme Court acknowledged that there are a number of federal appellate decisions holding

---

[3] The *Dukes* holding that Section 502(a) of ERISA completely preempts claims arising from utilization review decisions and plan benefit determinations means that such claims are also preempted under Section 514(a) of ERISA. It is well-settled that "[w]here a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Rice v. Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995).

[4] Justice Nigro asserted that, under the *Dukes* analysis, the third-party negligence claim against petitioner for refusing to pre-authorize coverage at Jefferson on account of its status as a non-participating hospital would not be preempted. App. 16a. However, that conclusion rests on a fundamental misunderstanding of *Dukes*. The Third Circuit held in *Dukes* that ERISA preempts claims arising from "pre-certification review" decisions by a plan administrator on requests for advance approval of hospital stays and medical procedures, which is precisely what has been challenged here. 57 F.3d at 359.

that Section 514(a) preempts negligence claims against health maintenance organizations which, like the claim asserted here against petitioner, arise from the administration and processing of claims for benefits under an ERISA-governed plan. App. 11a n.5. However, just as it refused to follow this Court's pre-*Travelers* decisions because it believed they were no longer good law, so too did it disregard the many relevant court of appeals' decisions, declaring that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." *Id.*

In fact, subsequent to *Travelers*, the federal courts of appeals have uniformly continued to hold that, under *Pilot Life*, Section 514(a) preempts claims arising from the administration of benefits under an ERISA plan, such as refusals to authorize coverage for a particular type of treatment or refusals to authorize coverage at a particular hospital. *See Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1008 (9th Cir. 1998) (claims arising from delay in authorizing bone marrow transplant were preempted, because "Prudential's alleged breach of fiduciary duty while administering the benefit plan is conduct covered by ERISA"); *Cannon v. Group Health Serv.*, 77 F.3d 1270, 1273 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996) (ERISA preempted suit arising from delay in authorizing bone marrow transplant, since the suit arose from "the improper processing of Mrs. Cannon's benefit claim"); *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997), *cert. denied*, 118 S.Ct. 1512 (1998) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant, since "a plan

administrator's refusal to pay allegedly promised benefits" is "related to" an employee benefit plan); *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1516 (1998) (ERISA preempted claim stemming from refusal to authorize coverage for high dose chemotherapy cancer treatment); *Engelhardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346, 1353 (11th Cir. 1998) (ERISA preempted tort challenge to plan's decision to deny plaintiff's claim for benefits); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (ERISA preemption applies to "allegations of negligence based on a failure to treat where the plan denied benefits for the proposed treatment"); *Parrino v. FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.), *cert. denied*, 119 S.Ct. 510 (1998) (ERISA preempted suit arising from plan administrator's delay in authorizing coverage for proton beam therapy, since plaintiff's claims "are predicated upon alleged improper handling of [plaintiff's] claim for treatment . . . ").

The Pennsylvania Supreme Court's decision also conflicts with a number of pre-*Travelers* court of appeals decisions which, relying upon *Pilot Life*, had found that ERISA preempted claims based on the alleged improper administration of benefits under a plan. *Kuhl v. Lincoln National Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994) (plan refused to certify payment for heart surgery at a hospital outside the plan's service area; "the decision not to precertify payment relates directly to Lincoln National's administration of benefits"); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992) (plan authorized home nursing care for pregnant woman

rather than hospitalization; "the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination"); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994) (ERISA preempted claim based on delay in authorizing coverage for bone marrow transplant; plaintiff's claim "seeks damages for the negligent administration of benefit claims"); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (claim based on allegedly unlawful termination of coverage was preempted; "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan . . . "); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (ERISA preempted claims arising from refusal to authorize psychiatric treatment under the plan; "American Biodyne and its employees were determining what benefits were available to Tolton under the plan.").

Petitioner's decision that Mr. Pappas would be afforded coverage if he was transferred to any of the three designated participating hospitals (Hahnemann, Temple University or Medical College of Pennsylvania), but not if he was transferred to a non-participating hospital (Jefferson), represents a prototypical administration of benefits determination. The negligence claim by Haverford attacking that benefits determination should have been found preempted in accordance with *Pilot Life* and all of the court of appeals' decisions cited above. The Pennsylvania Supreme Court's aberrational ruling that even administration of benefits determinations are not encompassed within the preemptive sweep of Section 514(a) has created a conflict that warrants certiorari.

The third-party complaint brought by Haverford complains not only of petitioner's refusal to pre-authorize coverage for Mr. Pappas at Jefferson, but also alleges that petitioner contributed to the delay in transferring Mr. Pappas from Haverford to a more suitable hospital.[5] App. 60a. The Pennsylvania Supreme Court stated that "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care" and are not preempted. App. 11a-12a. However, that ruling conflicts with five of the federal appellate decisions cited above, where the courts of appeals held that, under *Pilot Life*, ERISA preempts claims based on undue delays by plan administrators in approving particular treatments or benefits. *Bast v. Prudential Ins. Co.*, 150 F.3d 1003; *Cannon v. Group Health Service*, 77 F.3d 1270; *Kuhl v. Lincoln Nat. Health Plan*, 999 F. 2d 298; *Spain v. Aetna Life Ins.*, 11 F.3d 129; *Parrino v. FHP, Inc.*, 146 F.3d 699.

The decision below stands alone in its wholesale evisceration of the preemption defense that other courts have upheld for ERISA plan benefit determinations. The conflict between the Pennsylvania Supreme Court's decision and all of the federal court of appeals' decisions referred to above is stark, and that conflict can only be resolved by this Court.

---

[5] It took petitioner only fifteen minutes to provide Dr. Dickter with the names of three participating hospitals at which coverage for Mr. Pappas would be pre-approved. App. 21a, 36a.

III. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In The Lower Courts

Although this Court has rendered decisions in 17 cases addressing the boundaries of ERISA's preemptive reach,[6] it has not yet addressed ERISA preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations.

Lacking guidance from this Court, the federal and state courts have struggled mightily with the interplay of the preemption provision in Section 514(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. The courts have employed differing analytical frameworks, have reached widely divergent conclusions, and have created tremendous confusion, uncertainty and unpredictability in a vitally important area of the law that affects the tens of millions of people who participate in managed health care. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit

---

[6] *See DeBuono*, 520 U.S. at 808 n.1 and *UNUM Life Ins. Co. v. Ward*, ___ U.S. ___, 67 U.S.L.W. 4243 (April 20, 1999).

plans obtained through a qualified employer are within the scope of ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO or a self-funded plan.

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework . . . through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers . . . " B. Richardson, *Health Care: ERISA Preemption and HMO Liability – A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 Okla.L.Rev. 677, 679 (1996). The "myriad of confusion" that now exists in the federal and state courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

A very recent article points out that "[w]ith no specific guidance from the Supreme Court in this area, lower courts have floundered and strained" and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow and L. Greenlees, "ERISA Pre-emption – A Law in Search of a Doctrine," 27 Health Law Digest No. 3 (March, 1999) at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption

> issues. Second, the courts will continue to struggle by drawing distinctions – some meaningful, some not – in the hope of reaching results that are both equitable and in accord with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. *Accord* K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption,* 13 Yale J. on Reg. 255, 304 (1996) (after analyzing the numerous cases considering ERISA preemption of tort claims against HMOs, author concludes that "the outcomes on the issue of ERISA preemption have been inconsistent – indeed, the situation might be characterized as one of utter confusion on the issue"); P. Jacobson and S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence,* 35 Hous.L.Rev. 985, 1032 (1998) (lacking Supreme Court guidance, lower court decisions considering ERISA preemption in context of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity – exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here – Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs,* 30 Ga.L.Rev. 1023, 1051 (1996) (observing that courts have adopted divergent approaches in handling the issue of whether ERISA preempts malpractice claims against HMOs, and

"these various approaches have created incongruity and analytical inconsistency among courts").

ERISA preemption in the context of malpractice and negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal and state courts until this Court steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the lower courts in grappling with this difficult issue.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

[J-97-1997]

IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS and THEODORA PAPPAS, H/W,	:	No. 98 Eastern District Appeal Docket 1996
Plaintiffs,	:	Appeal from the Orders of the Superior Court Filed March 15, 1996 and May 23, 1996 at No. 2617 Philadelphia 1995, reversing the Order of the Court of Common Pleas of Delaware County at No. 92-3903
v.	:	
DAVID S. ASBEL, D.O.,	:	
Defendant,	:	
PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),	:	450 Pa. Super. 162, 675 A.2d 711 (1996).
	:	ARGUED: April 30, 1997
Defendants/Appellees	:	
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,	:	
Additional Defendant/ Appellant	:	

OPINION OF THE COURT

MR. JUSTICE CAPPY DECIDED: December 23, 1998

This is an appeal from the order of the Superior Court reversing the trial court's entry of summary judgment in favor of third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"). The issue on which this court granted allocatur is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, *et seq.*, preempts the state tort law claims brought against U.S. Healthcare. For reasons which differ from those relied upon by the Superior Court, we find that ERISA does not preempt these claims. We therefore affirm the order of the Superior Court.

At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.

Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further

treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:15 p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed

a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however, determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

In reviewing whether a trial court's award of summary judgment was appropriate, we view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre,* 532 Pa. 142, 144-145, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead*

---

[1] It is uncontested that U.S Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

Industries Assoc., Inc., 547 Pa. 224, 230, 690 A.2d 169, 171 (1997). As the issue presented in this case is one of law, our scope of review is plenary. *See Phillips v. A-BEST Products Co.*, 542 Pa. 124, 130, 665 A.2d 1167, 1170 (1995).

Our analysis begins with a review of the basic principles of preemption law. The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; . . . any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const., art. VI, cl. 2. It is this clause which gives to the United States Congress power to preempt state law.

In determining whether state law is preempted by a federal law, a reviewing court is cautioned that such a review "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless it [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407, 422 (1992) (citations omitted). Thus, Congress' intent is the "ultimate touchstone" in this analysis. *Id.*

A state law can be preempted in one of three ways. The first is where the United States Congress enacts a provision expressly preempting state law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n*, 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). Even where there is no explicit preemption provision, preemption will still be found where Congress has legislated the field so comprehensively that it has implicitly communicated the intent to occupy a given field to the exclusion of state law. *Schneidewind v.*

ANR Pipeline Co., 485 U.S. 293, 299-300, 1008 S.Ct. 1145, 1150, 99 L.Ed.2d 316, 325 (1988). Finally, a state law will be preempted where a state law actually conflicts with federal law. *Id. See also Cellucci v. General Motors Corp.*, 1998 WL 1333 (Pa. 1998).

It is this first method of preemption which is at issue in this matter. The express preemption provision in question states that "the provisions of this title . . . shall supersede any and all State laws[3] insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a).

None of the parties in this matter dispute that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against a health maintenance organization "relate to" an ERISA plan. U.S. Healthcare, however, cites to several United States Supreme Court cases from the 1980's and early 1990's as support for its contention that these claims should be preempted by ERISA.

U.S. Healthcare is indeed accurate in its claim that the Supreme Court had given the ERISA preemption provision an almost breathtaking scope in the 1980's and early 1990's. The Court stated that the preemption provisions were "deliberately expansive". *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39, 49 (1987). The Court at that time held the opinion that

---

[3] "State law" was defined by Congress as including "all laws, decisions, rule, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1). It is uncontested that a decision handed down by a state court, which would enter the common law of that state, is a "State law" as defined by ERISA.

"[t]he breadth of [§ 1144(a)'s] preemptive reach is apparent from that section's language." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490, 501 (1983). It declared that the words of the preemption provision were to be given their "broad commonsense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388, 85 L.Ed.2d 728, 740 (1985) (citations omitted). In the vast majority of cases concerning ERISA preemption addressed by the Court during this period, it was found that the state laws being reviewed had some "connection with" or "reference to" the ERISA plan. Although the Court did concede that the ERISA preemption provision "perhaps [is] not the model of legislative drafting" that the Court would hope for, *Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552, 95 L.Ed.2d at 47, the Court in the 1980's and early 1990's did not admit to any possibility that the plain meaning of the words of the preemption provision could not be given effect.

The Court noticeably changed tack in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). In *Travelers*, the unanimous Court determined that a New York statute which required hospitals to collect surcharges from patients covered by all commercial insurers other than Blue Cross/Blue Shield was not preempted by ERISA. After years of striving to make sense of the plain language of the preemption provision, the Court frankly admitted that the text is "unhelpful". *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705. The Court recognized that

"[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.' " *Id.* at 655, 115 S.Ct. at 1677, 131 L.Ed.2d at 705 (citations omitted). The Court reasoned that the language of the preemption provision is so extensive that if the Court were to look merely to the bare language of the provision, the provision would for all intents and purposes be without limit – an intent which the Court would not ascribe to Congress. *Id.* The Court concluded that "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line here," and that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705.

The Court determined that the "basic thrust of the preemption provision . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657, 115 S.Ct. at 1677-1678, 131 L.Ed.2d at 706. It recognized fairly significant bounds on the preemption provision when it stated that "[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability. " *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709 (citation omitted). The Court also cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically

has been a matter of local concern." *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709 (citations omitted).

The cases following *Travelers* have continued this trend. In *California Division of Labor Standards Enforcement v. Dillingham Construction, NA., Inc.*, ___ U.S. ___, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997), the majority relied upon *Travelers* to find that a California prevailing wage law was not preempted by ERISA. It is in the concurring opinion authored by Mr. Justice Scalia, however, that we find the most cogent recognition that the law of ERISA preemption had, in effect, been changed by *Travelers*. Mr. Justice Scalia opined that the cases from the 1980's and early 1990's, which were premised upon the now rejected notion that the plain language of the ERISA preemption provision could be given effect, were superannuated. He reproached the Court for not forthrightly acknowledging that the holdings of these older cases "have in effect been abandoned." *Id.* at ___, 117 S.Ct. at 843, 136 L.Ed. at 806 (Scalia, J., concurring). He believed that since *Travelers* recognized that literal interpretation of the provision "relate to" was unworkable, then earlier cases which concluded that the plain language of the preemption provision justified findings that the provision had "broad scope" and was "conspicuous for its breadth" were simply no longer good law. *Id.*

This new position on ERISA preemption was reiterated in *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, ___ U.S. ___, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997). The question presented in *De Buono* was whether a New York gross receipts tax could be applied to hospitals operated by ERISA plans. The Court again stated that the language "relates to" was unhelpful and that it must

instead explore Congress' intent in enacting ERISA in order to determine if a state law would indeed fall within ERISA's preemptive scope. *Id.* at ___, 117 S.Ct. at 1751, 138 L.Ed.2d at 29. The Court determined that the gross receipts tax was not preempted by ERISA because it was "one of myriad state laws of general applicability that impose (sic) some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute. . . . Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute." *Id.* at ___, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31 (citations omitted).[4]

Thus, although U.S. Healthcare is correct when it states that U.S. Supreme Court decisions from the 1980's and early 1990's support its position that the preemption provision is to be read broadly, *Travelers* and its progeny have thrown the expansive holdings of those earlier cases

---

[4] We note that another case concerning ERISA preemption was decided the same day *De Buono* was handed down. *Boggs v. Boggs*, ___ U.S. ___ 118 S.Ct. 9, 138 L.Ed.2d 1043 (1997). *Boggs*, however, does not lend anything to the analysis of the matter *sub judice*. In *Boggs*, the Court determined that Louisiana common law was preempted as it was in direct conflict with §§ 1055 and 1056 of ERISA, substantive provisions which limit the alienability of pension plan benefits from a surviving spouse. In this matter, it is not asserted that a claim of negligence lodged against an HMO is in conflict with any substantive provision of ERISA.

into question.[5] We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning contained within the *Travelers* line of cases, even though we recognize that the Court's earlier cases have not been expressly overruled.

Based upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not "relate to" an ERISA plan. As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709. Claims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe

---

[5] U.S. Healthcare also cites to a number of circuit court decisions which have held that claims against HMOs are preempted by ERISA. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Cannon v. Group Health Services of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996). Yet, the bulk of these cases were handed down prior to *Travelers*. The only one of these cases which was decided subsequent to *Travelers* – *Cannon* – fails even to mention *Travelers*. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions.

medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.[6]

Furthermore, we believe that negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans, as in the cases with many laws of general applicability," *Travelers*, 514 U.S. at 661, 115 S.Ct. at 680, 131 L.Ed.2d at 708-709, and therefore are not preempted. We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. As noted by the *De Buono* Court, an incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption. *De*

---

[6] The Superior Court below, in reasoning that ERISA does not preempt negligence claims lodged against HMOs, stated that "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted." *Pappas v. Asbel*, 450 Pa.Super. 162, 171, 675 A.2d 711, 716 (1996). The Superior Court concluded that Congress could not have intended to preempt that which it did not know would come into existence. We find that we are unable to adopt this reasoning that the modern day HMO was unforeseen by Congress when it drafted ERISA. Just one year preceding the enactment of ERISA, Congress enacted the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq*. The HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs.

Buono, ___ U.S. at ___, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31.

For the foregoing reasons, we conclude that ERISA does not preempt the claims in question. The order of the Superior Court is affirmed.[7]

Mr. Justice Nigro files a concurring opinion.

Judgment entered
Dated: December 23, 1998

/s/ John W. Person
John W. Person, Esquire
Deputy Prothonotary

---

[7] We also note that U.S. Healthcare puts great effort into arguing that it is not the negligent party here, and that Haverford and the physicians involved are solely responsible for the Pappas' injuries. U.S. Healthcare may ultimately be vindicated on these claims, but this is not the proper stage for these arguments. The issue with which we are concerned in this case is whether the claims against U.S. Healthcare are preempted; we have determined that they are not. It is now left for the fact-finder to determine if U.S. Healthcare's defenses to the negligence claims are valid.

[J-97-1997]
IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS AND THEODORA PAPPAS, H/W, Plaintiffs v. DAVID S. ASBEL, D.O., Defendant, Pennsylvania Hosp. Ins. Co. (Phico) and The Commw. of Pennsylvania Med. Professional Liab. Catastrophe Loss Fund (Cat Fund), Defendants/Appellees v. United States Healthcare Sys. of Pa., Inc., Additional Defendant/ Appellant	No. 98 Eastern District Appeal Docket 1996 Appeal from the Orders of the Superior Court filed March 15, 1996 and May 23, 1996 at No. 2617 Philadelphia 1995, reversing the Order of the Court of Common Pleas of Delaware County at No. 92-3903 450 Pa. Super 162, 675 A.2d 711 (1996) ARGUED: April 30, 1997

CONCURRING OPINION

MR. JUSTICE NIGRO DECIDED: December 23, 1998

I concur in the result reached by the Majority. I agree that the *Traveler's* line of cases in the United States Supreme Court supports the proposition that issues raising ERISA preemption are to be narrowly construed. I write separately, however, to explain why the present

negligence claim against U.S. Healthcare falls outside that narrow construction and is therefore not preempted. Here, the defendant physician and hospital brought U.S. Healthcare into the action claiming that it was U.S. Healthcare's refusal to authorize a medically necessary transfer which caused plaintiff's ultimate injury. Based upon the facts set forth in the Majority Opinion, I find that U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan. Here, the parties are merely attempting to assert their already existing rights under the generally applicable state law of agency and tort. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir. 1995), *cert. denied.*, 115 S. Ct. 564 (1995).

The federal courts have addressed issues similar to the present matter. *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990), presented an analogous situation as the injured party sued her HMO after receiving negligent medical treatment from a physician on its approved list. The *Smith* court, in finding the plaintiff's action was not preempted, stated that such a state tort action did not " 'impact upon' an employee benefit plan or 'affect the Congressional scheme contained in [ERISA]'." *Id.* at 988.

Moreover, as the Third Circuit recently explained, "patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan." *Dukes*, 57 F.3d at 358. *Dukes* explains that ERISA is principally concerned with the various mechanisms and institutions involved in the funding and payment of plan benefits and was intended

to provide each participant with a remedy in the event that promises made by the plan were not kept. *Id.* at 357. *Dukes* distinguishes between claims that the "quantum" of benefits promised were not provided, which *is* controlled by ERISA, and the "quality" of the benefits actually received, which is *not* controlled by ERISA. *Id. Dukes* concluded that "[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such." *Id.* I would adopt the rationale of the *Smith* and *Dukes* decisions and find that the negligence action against U.S. Healthcare is not preempted.

Therefore, I believe the overall purpose for the enactment of ERISA, as well as subsequent case law, would indicate that the negligence claim against U.S. Healthcare does not fall under the aegis of the preemption clause. It is for these reasons that I find state negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans. . . . " *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company et al.*, 514 U.S. 645, 661, 115 S. Ct. 1617, 1679 (1995) (citing *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 n.1, 113 S. Ct. 580, 583, n.1 (1992)).

J.A02006/96

BASILE PAPPAS & THEODORA PAPPAS, H/W/	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 2617 Philadelphia 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

ORDER

AND NOW, this 23rd day of May, 1996, IT IS HEREBY ORDERED:

THAT the application filed March 29, 1996, requesting reargument/reconsideration of the decision dated March 15, 1996 is DENIED.

PER CURIAM

J. A02006/96 – 1

BASILE PAPPAS & THEODORA PAPPAS, H/W	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 02617 PHILADELPHIA 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

Appeal from the Order Dated June 20, 1995, in the Court of Common Pleas of Delaware County, Civil Division, No. 92-3903

BEFORE: KELLY, HOFFMAN, JJ. AND MONTEMURO, J.*

JUDGMENT

ON CONSIDERATION WHEREOF, *it is now here ordered and adjudged by this Court that the judgment of the Court of Common Pleas of* DELAWARE *County be, and the*

same is hereby REVERSED AND REMANDED FOR FURTHER PROCEEDINGS.

BY THE COURT:

/s/ _____
PROTHONOTARY

Dated: MARCH 15, 1996

J. A02006/96 – 1

BASILE PAPPAS & THEODORA PAPPAS, H/W	:	IN THE SUPERIOR COURT OF PENNSYLVANIA
v.	:	
DAVID S. ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) & THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)	:	No. 02617 PHILADELPHIA 1995
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
APPEAL OF: PHICO INSURANCE COMPANY AND THE PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND	:	

Appeal from the Order Dated June 20, 1995, in the Court of Common Pleas of Delaware County, Civil Division, No. 92-3903

BEFORE: KELLY, HOFFMAN, JJ. AND MONTEMURO, J.*

OPINION BY MONTEMURO, J.: FILED MAR 15 1996

This appeal lies from an order granting summary judgment to appellee, United States Healthcare, Inc. (USHC), on the basis that the third party complaint of appellant Haverford Community Hospital is preempted by Section 1144(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*

On May 20, 1990, Basile Pappas, a subscriber to USHC, an HMO provided through his wife's employment, presented himself at the offices of his primary care physician, Dr. David Asbel, complaining of neck and shoulder pain. The treatment administered was an intramuscular injection of steroids. By the next day, Mr. Pappas' condition had deteriorated significantly, and, unable to walk, complaining of numbness in his arms, chest, abdomen and legs, he was transported to appellant Haverford Community Hospital at 11:00 a.m. There, after examination and preliminary testing which revealed an abnormally elevated white blood cell count, Mr. Pappas was preliminarily diagnosed as suffering from a cervical epidural abscess which was compressing his spinal cord. Dr. Dickter, the emergency room physician responsible for Mr. Pappas' care, determined that the case constituted a neurologic emergency requiring further, immediate

---

* Retired Justice assigned to Superior Court.

diagnosis and treatment at a university hospital with more extensive facilities than those available at Haverford.

After telephone consultation with Dr. Asbel, as well as Haverford's staff neurologist and neurosurgeon, arrangements were made by 12:30 to transfer Mr. Pappas to Thomas Jefferson University Hospital, which, possessing a spinal cord trauma unit, was able to assure Mr. Pappas' immediate admission. However, at 12:40 the ambulance service which was to transport Mr. Pappas informed the physicians at Haverford that as Jefferson was not an approved facility, authorization for Mr. Pappas' removal there was not forthcoming from USHC. At 12:50, Dr. Dickter telephoned USHC in an attempt to obtain authorization, and to do so quickly in view of the nature of the emergency. At 1:05, Dr. Dickter was informed by USHC that, after review, authorization for treatment at Jefferson was still being denied, but that Mr. Pappas could be removed to Hahnemann University, Temple University or Medical College of Pennsylvania. The USHC physician[1] who had made this decision refused to speak directly to Dr. Dickter, despite several requests that he do so, and after USHC was informed that Mr. Pappas' condition could worsen or become permanent. Rather, USHC's position was communicated through administrative personnel. Since Dr. Asbel expressed a preference for Hahnemann, that facility was contacted immediately but advised Haverford at about 2:20 p.m. that it would not have information on its ability

---

[1] The record does not reveal the field of specialization of this physician, a Dr. Liebowitz.

to receive Mr. Pappas for at least another half hour. MCP was then reached and within minutes notified the physicians that it could accept Mr. Pappas, who was ultimately transported there at about 3:30 p.m. Mr. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Mr. Pappas brought suit against Asbel and Haverford, claiming various forms of malpractice as to the former, and as to the latter, negligence in causing an inordinate delay in transferring him to a facility equipped and immediately able to address the neurological emergency, thus exacerbating the compression of the spine which caused his quadriplegia. Haverford then filed a third party complaint against USHC, joining it as a party defendant for its refusal to authorize the transfer of Mr. Pappas to the hospital selected by the Haverford physicians, and adopting the negligence claims lodged against it in the original complaint. In his answer and new matter, Dr. Asbel filed a cross claim against USHC seeking contribution and/or indemnity. After filing both Answer and New Matter and Preliminary Objections, which failed to mention preemption, USHC successfully filed a motion for summary judgment alleging that the third party complaint should be dismissed, having been preempted by § 1144(a) of ERISA. This appeal followed,[2] presenting the question of whether ERISA was correctly determined to

---

[2] Mr. Pappas' claims against Dr. Asbel and Haverford were settled by agreement of the parties, and Haverford's interests vis a vis USHC are now represented by the Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Catastrophic Loss Fund.

preempt Haverford's claim, characterized by appellant as a state law claim unrelated to ERISA or employee benefits, against USHC.[3]

In reviewing a grant of summary judgment we must determine whether, in view of the pleadings, depositions, answers to interrogatories, admissions on file, together with any affidavits, any genuine issue of material fact exists in the case, and, if not, whether the moving party is entitled to judgment as a matter of law. Moreover, the moving party's right to such a judgment must be clear and free from doubt. *Musser v. Vilsmeier Auction Co., Inc.*, 522 Pa. 367, 562 A.2d 279 (1989); Pa.R.C.P. 1035.

29 U.S.C. § 1144(a) reads in pertinent part as follows:

> Except as provided in subsection (b) of this section, the provisions of this title . . . shall

---

[3] There is no question that USHC is an employee benefits plan as defined by ERISA, 29 USCS § 1002(1):

> The terms "employee welfare benefit plan" and welfare plan mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, (A) medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefits described in section 3023(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

> supersede any and all State laws *insofar as they* may now or hereafter *relate to* any employee benefit plan . . . (emphasis added).

It may, without fear of contradiction, be asserted that the Supremacy Clause, United States Constitution, Art. VI, expressly or by implication commands preemption of a state law where such law conflicts with federal law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Commission*, 461 U.S. 190 (1983). It is also well settled that ERISA's supersession provision is vast in its application. *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). However, the question still remains as to the precise reach of the phrase "insofar as they . . . relate to . . . " In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the United States Supreme Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 97. The trial court in this matter found that the allegations in Haverford's third party complaint all "f[e]ll within the rubric of administration of an employee benefit plan" because they concerned specific actions taken by USHC, namely its refusal to approve Mr. Pappas' transfer to a facility where the care he needed was available immediately as the emergent nature of his condition required.

Because the limitations supplied by the cases attempting to define "relate to" are necessarily vague, the district and circuit courts which have considered the matter of HMO involvement are split on the precise extent of ERISA's reach. A number of federal court cases impose preemption on efforts to hold an HMO liable for injuries resulting from certain of its decisions on the basis

that any attempt to seek redress constitutes an attack on the administration of the HMO, the position adopted by the trial court herein, and thus imposes a restriction such as the Act seeks to avoid. *See, e.g., Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 114 S.Ct. 694 (1994) (claim against HMO for denying surgical precertification preempted by ERISA); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (1992), *cert. denied*, 113 S.Ct. 812 (1992) (claims against HMO for failure to provide hospitalization to expectant mother resulting in death of unborn child); *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (1993) (claim against HMO for refusing to precertify surgery which could only be performed at hospital outside HMO service area, causing delay in surgery resulting in death of beneficiary). All of these cases have in common the reasoning that the state law claims involved necessarily "relate to" administration of the plans in question and are therefore preempted under the broad sweep of § 1144(a).

The United States Supreme Court, however, albeit in dealing with factual settings which differ from the sorts of claims involved in these cases, has refined the "relate to" language, thus truncating it to some extent. In *Mackey v. Lanier Collection Agency and Service*, 486 U.S. 825 (1988), attendant upon a finding that a state garnishment action against participants in an ERISA plan providing vacation and holiday benefits was not preempted, the Court noted:

> ERISA plans may be sued in a second type of civil action as well. These cases – lawsuits against ERISA plans for run of the mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan – are relatively commonplace. Petitioners and

> the United States (appearing here as amicus curiae) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA § 514(a).

Id. at 833. (emphasis added).

In the recent case of *New York Blue Cross v. Travelers Insurance Co.*, 115 S.Ct. 1671 (1995), the Court has indicated that § 1144(a) may well be further limited. There, the Court examined a New York statute which requires hospitals to collect surcharges from patients covered by designated commercial insurers and imposes a surcharge on certain HMO's, but exempts from the surcharges those patients insured by a Blue Cross/Blue Shield plan. In holding that the surcharge provisions do not "relate to" employee benefit plans, the Court noted that the language of ERISA is so expansive as to be, for all practical purposes, infinite: unless read in conjunction with the structure and purpose of the statute as a whole, the words of limitation, "insofar as they . . . relate to . . . ," are not limiting at all, and Congress' intention must be interpreted as a sham. *Id.* at 1677. Rather, the Court determined to "go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* The Court then observed that "[t]he basic thrust of the preemption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," *id.* at 1677-78, that is, to protect it from conflicting directives. However, the Court went on to note that "nothing in the language of the Act or the context of its passage

indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 1680. The Court extrapolated from its findings that "a law operating as an indirect source of merely economic influence on administrative decisions . . . should not suffice to trigger preemption." *Id.*

This last is especially pertinent to the question presented here despite the variance in context. What is at issue is a negligence claim identical to the one lodged against Haverford by Mr. Pappas in the underlying complaint. The type of recovery sought is based on negligence attributable to the delay occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries. Decisions such as that made by USHC concerning where Mr. Pappas might receive treatment are propelled by dollar savings, not the protection of worker's rights, in this case the right to the most effective medical care, which was the original focus of ERISA. In fact, the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations.

Considerations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted. It cannot therefore be argued that the type of recovery sought here was deliberately excluded from the Congressional scheme in order to protect ERISA plans from conflicting directives which would, in attempting to control expenses, affect medical judgments. A tort claim such as

that advanced here is, in fact, "an indirect source of merely economic influence on administrative decisions." *Id.* To find that such claims are preempted because they may interfere with what is in essence a business decision made in the financial interests of a commercial entity is inconsistent with the intention of ERISA and should not "suffice to trigger preemption." *Id.*

This conclusion is consistent with cases in which courts found that a particular state claim is not preempted, based on the rationale that the state law involved affects ERISA in an indirect manner, or is so tenuous or remote as to obviate the necessity for preemption. *Greenblatt v. Budd,* 666 F.Supp. 735, 741 (E.D. Pa. 1987) (common law action for misrepresentation by employee whose pension benefits were denied after company merger not preempted.) To make such a determination, it is the state statute which must be examined, and an assessment made of whether the action represents exercise of a classically important state function preempted neither expressly or impliedly by ERISA. *Id.* Contrast, *Memorial Hospital System v. Northbrook Life Insurance Company,* 904 F.2d 236 (5th Cir. 1009) (action for deceptive trade practices by health care provider against plan trustees not preempted, because enforcing allocation of risks between commercial entities conducting business in a state is a classically important state interest, and because health care provider is not a party to plan.) General health care regulation is, as has already been noted, traditionally an area of state concern. *New York Blue Cross, supra.*

While decisions of the federal district courts and courts of appeal, including those of the Third Circuit, are not binding on Pennsylvania courts, even where a federal

question is involved, *Breckline v. Metropolitan Life Insurance Company*, 406 Pa. 573, 578, 178 A.2d 748, 751 (1962), they are both persuasive as to federal questions, *Chiropractic Nutritional Associates, Inc. v. Empire Blue Cross and Blue Shield, Inc.*, ___ Pa. Super. ___, ___ A.2d ___ (Nos. 62-69 Pittsburgh 1995, Slip Op. at 10 filed Dec. 29, 1995), and those of the Third Circuit are appropriate for this court to follow where the United States Supreme Court has not spoken. *Id.* In *Dukes v. US Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir. 1995) (claims for direct negligence of HMO remanded to state court for determination of whether preemption was mandated),[4] the Third Circuit recognized that "Quality control of benefits . . . is a field traditionally occupied by state regulation, and we interpret the silence of Congress as reflecting an intent that it remains so." *See also, Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (1990) (state court action for medical malpractice under ostensible agency theory not preempted by ERISA).

In *Krashna v. Oliver Realty, Inc.*, 895 F.2d 111 (3d Cir. 1990), albeit in another context, the Court of Appeals for the Third Circuit stated that in order to show that what

---

[4] Appellee argues that this case is inapposite as it concerned only the issue of whether it was proper to remove the case to federal court based on ERISA's preemption provision – no decision was reached as to whether this provision actually applied. However, as appellant points out, the court was not able to articulate any plan-created right that was threatened by the plaintiffs' state law negligence claims. Had it been able to do so the decision as to preemption would not even be regarded as equivocal; the claim would have been dismissed.

purports to be a state law claim is completely preempted by federal statute, two factors must be shown:

> First, "the statute relied upon by the defendant as preemptive [must] contain [ ] civil enforcement provisions within the scope of which the plaintiff's state claim falls." . . . The federal statute must subsume the interest vindicated by the state law, not the remedy provided. . . . Second, there must be "a clear indication of a Congressional intention to permit removal despite the plaintiff's exclusive reliance on state law."

Id. at 114, quoting *Railway Labor Executives Ass'n v. Pittsburgh & L.E. R.R.*, 858 F.2d 936, 942 (3d Cir. 1988). *See also, Plucinski v. I.A.M. National Pension Fund, et al.*, 875 F.2d 1052 (3d Cir. 1989) (In accountancy malpractice case brought by a plan, the conclusion was reached that ERISA does not generally preempt state professional malpractice claims.)

ERISA's civil enforcement provision, § 1132(a)(1)(B), permits beneficiaries of employee welfare plans to "recover benefits due . . . under the terms of the plan," "to enforce . . . rights under the terms of the plan or to clarify rights to future benefits under the terms of the plan." As the *Dukes* court observes,

> Inherent in the phrases "rights under the terms of the plan" and "benefits due . . . under the terms of [the] plan" is the notion that plan participants and beneficiaries will [by means of litigating tort claims] receive something to which they would not otherwise be entitled. But patients enjoy the right to be free from medical malpractice regardless of whether or not their

medical care is provided through an ERISA plan. *Id.* at 358.

This court has ruled that negligence claims are not preempted by ERISA, as they are not "related to" it. *See, McClellan v. Health Maintenance Organization of Pennsylvania,* 413 Pa. Super. 128, 604 A.2d 1053, *appeal denied,* 532 Pa. 664, 616 A.2d 985 (1992) (suit based on liability of HMO for negligence of agent/physician and on intentional misrepresentation or fraud by HMO itself); *DeGenova v. Ansel,* 382 Pa. Super. 213, 555 A.2d 147 (1988) (suit based on vicarious liability of HMO for the negligence of its agent/physician). Nor are these claims covered by ERISA's civil enforcement provisions. The *DeGenova* court specifically found that the "appellants were not seeking ERISA benefits or claiming improper distribution or administration of ERISA benefits," *Id.* at 219, 555 A.2d at 150, and thus preemption did not apply.

The negligence claims at issue here too have, in fact, no connection to the benefit scheme which Congress sought to protect by preempting laws tending to produce conflicting systemic demands; ERISA is in no way implicated by the claim that USHC negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer. Appellants do not seek benefits denied, because Mr. Pappas was transferred to a hospital capable of supplying the needed services; they do not seek to challenge the administration of the Plan, again because there is no complaint that USHC did not perform its duties. Rather, the argument is that USHC performed its duties in a negligent manner given the exigent nature of the emergency. Finally, if the original complaint had claimed that USHC was vicariously liable because of the negligence of

its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question under *McClellan* and *DeGenova* that the claim would withstand preemption.

As the *Corcoran* court points out, to conclude that the preemption of all other claims was incorporated into Congress' intent in enacting ERISA necessarily assigns to Congress the concomitant intent to deprive plaintiffs injured by such negligence of any remedy, state or federal, for serious errors perpetrated by HMO's. However, the Supreme Court of the United States, in analyzing the application of preemption clauses in other statutes, found it "difficult to believe that Congress would, without comment, remove all judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corporation*, 464 U.S. 238, 251 (1984) (Award of punitive damages arising out of escape of plutonium from federally licensed nuclear facility not preempted by Atomic Energy Act). *See also, United Construction Workers v. Laburnum Construction Corporation*, 347 U.S. 656 (1954).

We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system which inheres in USHC's review process, to foreclose recovery to plan beneficiaries injured by negligent medical decisions. We therefore conclude that the negligence claims against appellee are not preempted by ERISA.

The question then becomes what, if any, impact the procedural posture of this case has on the implementation of the preemption provision. The trial court concedes that the "no relation" theory may be a valid one, but

concludes that because Haverford Hospital and not Mr. Pappas joined USHC as a party defendant, no theory of recovery which would otherwise be available could apply. Pa.R.C.P. 2255(d) dispenses with such a distinction:

> The plaintiff shall recover from an additional defendant found liable to him alone or jointly with the defendant as though such defendant had been joined as a defendant and duly served and the initial pleading of the plaintiff had averred such liability.

See also, Solomon v. Cedar Acres East, Inc., 455 Pa. 496, 317 A.2d 283 (1974).

The effect of a third party complaint joining an additional defendant is thus to make the additional defendant "immediately subject to the plaintiff's claim in every respect and with the same force and effect as if the additional defendant had been originally named as the defendant" in the plaintiff's complaint. *3 Standard Pennsylvania Practice 2d* (1994), § 14:359. The character of the claim does not alter with the procedure used to present it.

Accordingly, we reverse the trial court's order granting summary judgment and remand for further proceedings consistent with this Opinion.

IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

BASILE PAPPAS and THEODORA PAPPAS, Plaintiffs	:	NO. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL, and UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. Defendants	:	

ORDER

KEELER, J. FILED:

AND NOW, this 3rd day of June, 1994, upon consideration of the motion for Summary Judgment filed by United States Healthcare Systems of Pennsylvania, Inc. (USHC), the various responses filed by the other parties and the memoranda submitted, it is hereby ORDERED that USHC's motion for Summary Judgment is GRANTED.

BY THE COURT:

/s/ Charles C. Keeler, J.
CHARLES C. KEELER, J.

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEODOREA PAPPAS, his wife,	:	NO. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL	:	
vs.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	

OPINION

KEELER, J. FILED:

I. FACTS

On or around May 20, 1991, the plaintiff, Basile Pappas, presented himself at the offices of Dr. David Asbel, complaining of neck and shoulder pain. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of medication. Despite this treatment, plaintiff alleges that his condition worsened. The following morning his deterioration manifest itself by rendering Mr. Pappas immobile and by causing numbness in his extremities. He was transported via ambulance to the Haverford Community Hospital ("Haverford") on the morning of May 21, 1991. The plaintiffs provided the hospital with information regarding HMO-PA in order to satisfy the hospital of financial responsibility. Both Mr. and Mrs. Pappas subscribed to HMO-PA through an

employees' health benefits plan provided to Mrs. Pappas by her employer, The Charming Shoppes. HMO-PA is owned by additional defendant U.S. Healthcare Systems of Pennsylvania, Inc. ("USHC"). He was admitted at approximately 11:00 a.m. to the hospital's emergency room. Dr. Steven J. Dickter examined Mr. Pappas and ordered a blood study. The analysis revealed an elevated white cell count. These results in conjunction with the patient's subjective complaints and physical ailments led Dr. Dickter to the conclusion that Mr. Pappas was suffering from an epidural abscess which pressed upon Mr. Pappa's spinal column.

Dr. Dickter consulted with Dr. Slater, a neurologist at Haverford who concurred that the situation constituted a neurologic emergency. This determination was also confirmed by a consultation with Dr. Yablon, a Haverford neurosurgeon. Given the circumstances, Dr. Dickter felt it would be in the patient's best interest to receive treatment at a "university" hospital. Dr. Dickter made arrangements to transfer Mr. Pappas to Jefferson University Hospital for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that Jefferson was not an approved hospital for HMO-PA. Ten minutes later, Dr. Dickter contacted HMO-PA to inquire as to Jefferson's status as an approved facility. Nearly 15 minutes later, HMO-PA responded to Dr. Dickter's inquiry and advised him that Jefferson was not an approved facility, but that the patient could be transferred either Hahnemann, Temple or Medical College of Pennsylvania ("MCP").

Dr. Dickter then telephoned Dr. Asbel and sought his preference concerning the patient's destination. Dr. Asbel

expressed a preference for treatment by Dr. Black at Hahnemann. Dr. Dickter promptly telephoned Hahnemann to advise them of the emergency situation and to secure information regarding the transfer into Dr. Black's care. After the passage of five minutes, Dr. Dickter again called and found that his contact person was still checking on intensive care unit bed space availability. At approximately 2:20 p.m. Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before any information could be provided as to Hahnemann's ability to accept Mr. Pappas as a patient. Dr. Dickter then telephoned Dr. Mucci at MCP to ascertain whether the patient could be transferred to that facility. Within ten minutes Dr. Mucci returned the call and expressed that the patient could be accepted. Ultimately, Mr. Pappas was transported to MCP.

This lawsuit was brought as a consequence of the injuries allegedly sustained by Mr. Pappas resulting from delay in treatment while Haverford's staff attempted to make appropriate arrangements for care of the plaintiff's neurologic emergency. Plaintiff alleges that the delay exacerbated his spinalcord compression which resulted in quadriplegia. Haverford filed a third party complaint joining USHC as a third party defendant for their refusal to authorize a transfer of Mr. Pappas to a hospital selected by the physicians at Haverford. Moreover, the third party complaint suggests that USHC is liable over to Haverford for any award which might result from this action. Dr. Asbel, in his answer and new matter, filed a cross claim seeking contribution and/or indemnity from the third party defendant, USHC.

II. PROCEDURAL POSTURE

Third party defendant, USHC, has filed a motion for Summary Judgment alleging that the third party complaint filed by Haverford must be dismissed under the preemption provisions of the Federal Employee Retirement Income Security Act of 1974 (ERISA). *See* 29 U.S.C. § 1001, *et seq.* (1990). Haverford has responded by asserting that this court lacks jurisdiction to either determine whether ERISA preempts state law or the substance of HMO-PA's preemption arguments.

Any intelligent analysis of the issues raised must be predicated on an understanding of the nature of the ERISA provisions and a fundamental understanding of the nature of preemption. As such, we will address those issues first.

III. DISCUSSION

As a threshold matter, the court must determine whether it has jurisdiction to render any decision in regard to the present litigation. Haverford conveniently ignores a number of cases which decided issues involving ERISA claims. Inferentially, the fact that our appellate courts would consider the substance of such matters suggests that no legal impediment exists which divests a state court of jurisdiction over such issues. *See McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied*, 532 Pa. 664, 616 A.2d 985 (1992); *DeGenova v. Ansel*, 382 Pa.Super. 213, 555 A.2d 147 (1988).

Haverford has failed to identify any specific provision of ERISA which would divest this court of jurisdiction. Instead, it directs our attention to language in the statute which provides that Federal courts, with certain exceptions, shall have exclusive jurisdiction of civil actions brought by the Secretary of Labor or by a plan's "participant, beneficiary or fiduciary." 29 U.S.C. § 1132(e)(1). Certainly, Haverford's cross-claim is in the nature of a civil action. However, Haverford cannot maintain that its third party action is brought "by the Secretary of Labor or by a plan's 'participant, beneficiary or fiduciary'." All of these parties (as defined by ERISA) are individuals. No corporate entity such as Haverford may avail itself of the exclusive jurisdiction of the Federal courts under this specific provision. *See* 29 U.S.C. § 1002(7) (participant defined), 1002(8) (beneficiary defined) & § 1109 (fiduciary defined).

Having determined that this court possesses jurisdiction to decide the preemption issue we may now address the substance of the argument.

Under the Federal Constitution legislation enacted by the Federal government "shall be the supreme Law of the Land . . . " U.S.Const.Art. VI, cl.2. Thus, any state law which conflicts with federal law is "without effect." *Maryland v. Louisiana*, 451 U.S. 725, 746, 101 S.Ct. 2114, 2128, 68 L.Ed.2d 576, 595 (1981). Nevertheless, any issue arising under the supremacy clause assumes that the historic police powers of the individual states are not to be superseded by federal legislation unless it is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947).

The intent of Congress may be "explicitly stated in the statute's language or implicitly contained in its structure in purpose." *Jones v. Rath Packing Co.*, 430 U.S. 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604, 614 (1977). In the absence of an express congressional command, state law is preempted to the extent it conflicts with federal law. *See Pacific Gas & Elec. Co. v. Energy Resources Conservation and Development Comm'n.*, 461 U.S. 190, 204, 103 S.Ct. 1713, 1722, 75 L.Ed.2d 752, 765 (1983). State laws are also rendered ineffectual if a federal law so thoroughly occupies a legislative field as to make it reasonable to infer that Congress left no room for the States to supplement it. *Fidelity Fed. Savings & Loan Assoc'n. v. De La Cuesta*, 458 U.S. 141, 153, 102 S.Ct. 3014, 3022, 73 L.Ed.2d 664, 675 (1982).

ERISA specifically provides that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(1). The language of the ERISA statute sweeps broadly by superseding all state laws relating to any employee benefit plan. *Morales v. Trans World Airlines, Inc.*, ___ U.S. ___, 112 S.Ct. 2031, 2037, 119 L.Ed.2d 157, 168 (1992) (breadth of scope of ERISA unmistakably relies on "express preemption and construction of the phrase 'relates to' "); *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990) ("deliberately expansive"); *FMC v. Holliday*, 498 U.S. 52, 58, 111 S.Ct. 403, 407, 112 L.Ed.2nd 356, 364 (1990) ("conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490, 501 (1983) (breadth of ERISA's "preemptive reach is apparent from [its] language").

Nevertheless, the preemption clause does not bar all claims. *See* e.g. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833, 108 S.Ct. 2182, 2187, 100 L.Ed.2d 836, 846 (1988) (state garnishment of ERISA welfare Benefit Plan not preempted; such plans may be subject to suit for state law violations, contractual obligations and torts which are unrelated to the plan's administration).

The crux of the issue then seems to be whether ERISA's preemption provision which provides that any and all state laws are superseded insofar as they "relate to any employee benefit plan" bars Haverford's claims against USHC. *See* 29 U.S.C. § 1144(a). Haverford's third party complaint attempts to establish the liability of USHC by showing that USHC "refused to authorize transfer of [Mr. Pappas] . . . to a hospital selected by physicians at Haverford . . . as being able to minister to him." *See* Haverford's third party complaint at paragraph 7. In addition, the third party complaint incorporates by reference the allegations of paragraph 24 of plaintiff's original complaint. That paragraph asserted that Haverford . . . was negligent in failing to transfer [Mr. Pappas] . . . to another medical facility in a prompt and timely fashion and that Haverford . . . inordinately delayed the transfer. *See* plaintiff's complaint at paragraph 24. All of these allegations fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision. We must therefore conclude that Haverford's efforts to pursue its third party complaint are barred.

Haverford relies upon inapposite caselaw in support of its contentions. The imposition of a local income tax on

employees despite their status as ERISA participants does not implicate a relationship to any employee benefit plan in a substantive sense. *See Firestone Tire and Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987). Nor does the application of a local tax affect the administration of an employee benefit plan in any substantive sense; thus, mandating the preemption of the action. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, 47-48 (1987) (decisional common law cause of action for improper benefit claim processing barred by ERISA because it relates to employee benefit plan).

A number of courts have held that state claims are preempted by ERISA where suit is filed to hold an HMO responsible for injuries resulting from the HMO's own negligent administration of cost containment procedures and funding decisions. *Kuhl v. Lincoln Nat'l. Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ERISA preempts plaintiff's claim against HMO for denying surgical precertification), *cert. denied* 114 S.Ct. 964 (1994); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1331 (5th Cir.) (ERISA preempts claim for erroneous medical decision rendered in context of determining plan benefits, *cert denied* 113 S.Ct. 812 (1992); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290-91 (E.D.Pa 1992) (ERISA preempts direct liability claim for failure to fund medical device). In all of these cases, preemption was based upon the fact that the failure to pay a benefit claim or preapprove a procedure possessed an obvious connection or reference to a benefit plan and therefore related to it. Other courts have decided that ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability

generally or ostensible agency specifically. *Elesser, supra,* at 1290 (plaintiff's claim alleging vicarious liability of HMO for actions of position acting ostensible as HMO's agent not preempted); *Independent HMO v. Smith,* 733 F.Supp. 983, 988 (E.D.Pa. 1990) (same). These cases apply the rationale that the negligence claims have no relationship to a denial of rights under the benefit plan since they do not affect the regulatory scheme devised by Congress in ERISA. Thus, such claims are not sufficiently "related to" ERISA such as to warrant preemption. *See generally Boyd v. Albert Einstein Medical Center,* 377 Pa.Super. 609, 619-20, 547 A.2d 1229, 1234 (1988) (adopting Restatement (Second) of Agency section 267 which outlines the theory of ostensible agency). Given the procedural posture of this case and the fact that Haverford Hospital and not the plaintiff joined USHC to the action, neither of these theories is applicable in this case.

Here, Haverford Hospital seems to suggest that USHC is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under USHC's programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan. As such, Haverford's motion for Summary Judgment must be denied.

Haverford's final argument concerning ERISA's civil enforcement scheme demonstrates a basic misconception of the ERISA statute. Clearly, certain enumerated and defined parties may seek to invoke ERISA's civil enforcement remedies. 29 U.S.C. § 1132. However, Haverford seems to confuse standing to maintain an action with

preemption. The fact that ERISA provides standing to specified categories of individuals which limits redress does not translate to a waiver of preemption. In any event, as observed previously, Haverford, as a corporate entity, possesses no standing to maintain a civil action under ERISA.

For the foregoing reasons, USHC's motion for Summary Judgment was granted.

BY THE COURT:

/s/ Charles C. Keeler
CHARLES C. KEELER, J.

STEPHEN A. RYAN, P.C.
By: Stephen A. Ryan, Esquire
Identification Nos. 21645

Suite 227, Bala Pointe
111 Presidential Boulevard
Bala Cynwyd, PA
19004-1071
(215) 664-1100

Attorney for Defendant, Haverford Community Hospital

BASILE PAPPAS & THEODORA PAPPAS, his wife,	:	COURT OF COMMON PLEAS
v.	:	
DAVID S. ASBEL, D.O.	:	DELAWARE COUNTY, PA
and	:	
HAVERFORD COMMUNITY HOSPITAL	:	
(Defendant & Third Party Plaintiff)	:	NO. 92-3903
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	
(Third Party Defendant)	:	

ORDER

Having been apprised that Plaintiffs have entered into an Agreement of Settlement of the above lawsuit

with Defendants, David S. Asbel, D.O. and Haverford Community Hospital, and the details thereof; and that Plaintiffs have agreed to execute a Release in a form acceptable to said Defendants and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund"), Plaintiffs' counsel to be party to a part thereof;

It is the opinion of this Court that said Settlement is not only fair, but reasonable to all parties.

In view thereof, it is hereby ORDERED AND DECREED:

1. Defendant(s) may file an amended answer(s) asserting the Release and that they have discharged the common liability of all persons and entities;

2. Pennsylvania Hospital Insurance Company (PHICO) and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") are hereby substituted for Haverford Community Hospital as the real parties in interest;

3. Under the present circumstances, the Order of this Court dated June 8, 1994, denying the application of Haverford Community Hospital for a determination of finality of its June 3, 1994 Order granting Summary Judgment to Third-Party Defendant, U.S. HealthCare Systems of Pennsylvania, Inc. is vacated, and the application for a determination of finality is hereby granted, for the purpose of pursuing a determination of Assignees' claims for contribution and indemnity.

/s/ Charles C. Keeler, J.
J. 6/13/95

BEASLEY, CASEY, COLLERAN, ERBSTEIN, THISTLE & KLINE
BY: JAMES E. COLLERAN, ESQUIRE
ATTORNEY FOR: PLAINTIFFS
IDENTIFICATION NO. 09367
1125-35 WALNUT STREET
PHILADELPHA, PA 19107-4997
592-1000

BASILE PAPPAS and THEODORA PAPPAS, his wife, 3421 West Chester Pike Newtown Square, PA 19073	:	COURT OF COMMON PLEAS DELAWARE COUNTY CIVIL ACTION - LAW JURY TRIAL DEMANDED NO. 92-3903
Plaintiffs,	:	
vs.	:	
DAVID S. ASBEL, D.O. 3501 West Chester Pike Suite 101 Newtown Square, PA 19073	:	
and	:	
THE HAVERFORD COMMUNITY HOSPITAL 2000 Old West Chester Pike Havertown, PA 19083	:	
Defendants.	:	

CIVIL ACTION (COMPLAINT)

1. The plaintiffs are Basile and Theodora Pappas, individuals, citizens and residents of the Commonwealth

of Pennsylvania, residing therein at 3421 West Chester Pike, Newtown Square, PA 19073. Husband-plaintiff Basile Pappas brings a claim for direct personal physical and mental injury, and his wife, Theodora Pappas, brings a derivative claim, for loss of consortium and related damages, as will be described hereafter.

2. Defendant David S. Asbel, D.O. is an osteopathic physician, duly authorized and licensed to practice medicine within the Commonwealth of Pennsylvania, with offices at 3501 West Chester Pike, Newtown Square, PA 19073. At various material to the events described within this Complaint, defendant Dr. Asbel was the treating family physician of plaintiff Basile Pappas.

3. On May 20, 1991, Basile Pappas went to the offices of the defendant Dr. Asbel, and complained to Dr. Asbel of severe neck and shoulder pain of several days' duration. Mr. Pappas also informed Dr. Asbel that he was quite concerned over his condition because he had begun to experience bizarre feelings in his arms and legs, with onset of weakness of the extremities on that morning.

4. On May 20, 1991, defendant Dr. Asbel performed an intramuscular (IM) injection of plaintiff's neck, and advised him that he had administered steroids into the neck. On that occasion, Dr. Asbel prescribed Soma Compound with codeine to be taken by the patient, and informed the patient that he had somatic dysfunction.

5. After the office visit, the plaintiff returned home and continued to experience his ongoing severe neck pain, shoulder pain, weakness of extremities, altered and peculiar sensation within the extremities, and loss of well-being.

6. In the evening of May 20, 1991, when plaintiff's condition appeared to be progressing and deteriorating, his wife, Theodora Pappas, called the offices of the defendant, who returned her call. During that telephone conversation, Mrs. Pappas informed Dr. Asbel that her husband was experiencing worsening of the feeling of numbness of his extremities, that his extremities were ice-cold, that he had severe neck pain, that both she and her husband were very concerned about his situation, and Mrs. Pappas asked Dr. Asbel to do what was necessary.

7. During the conversation described in the preceding paragraph, defendant Dr. Asbel advised Mrs. Pappas to call him in the morning if Mr. Pappas was not better.

8. During the early morning hours of May 21, 1991, when plaintiff's condition continued to deteriorate, and when he was unable to void, Mrs. Pappas once again contacted Dr. Asbel, who repeated instructions to call him in the morning if Mr. Pappas was no better.

9. In the early morning of May 21, 1991, Mrs. Pappas again contacted Dr. Asbel, and told him that her husband was unable to move, had complete numbness of all extremities, as well as other signs and symptoms then present. On that occasion, Dr. Asbel informed Mrs. Pappas to summon an ambulance, and to have her husband taken to the Haverford Community Hospital.

10. The ambulance crew of the ambulance summoned took a great deal of time in making Mr. Papas ready for ambulance transportation to the Haverford Community Hospital, where he was admitted at 11:01 a.m. on May 21, 1991.

11. Mr. Pappas was admitted to Haverford Community Hospital on a stretcher, alert and verbally responsive, complaining of neck pain since May 17th, which had been treated by Dr. Asbel on May 20th with a steroid injection into the left cervical region. The admission history recorded that Mr. Pappas was presently unable to walk. Emergency room personnel contacted Dr. Asbel for instructions.

12. Plaintiff remained at the Haverford Community Hospital from 11:00 a.m. until he was transferred to the Medical College of Pennsylvania (MCP) at or about 3:30 p.m.

13. While the patient was at Haverford Community Hospital, the physicians there made a probable diagnosis of cervical epidural abscess, requiring neurosurgical decompression.

14. While Mr. Pappas remained at the Haverford Community Hospital, physicians there attempted to place him at a university hospital, where surgical decompression could be done.

15. X-rays done of the plaintiff while he as at Haverford Community Hospital showed hypertrophic spondylosis of the cervical spine with disc space narrowing at the level of C-5/C-6.

16. Mr. Pappas was admitted to the emergency room of the Medical College of Pennsylvania (MCP) at or about 4:04 p.m. on May 21, 1991, in a condition of quadriplegia. On admission there, the plaintiff gave a history of gradual onset of weakness beginning the previous day

(May 20th). The patient also gave a history of a deterioration of his condition on May 20th, to the point where he became unable to void on May 20th.

17. Mr. Pappas was admitted to the service of Warren Goldman and David Swingle, both neurosurgeons. An emergency myelogram showed a complete block at the level of C-6.

18. Mr. Pappas was brought to surgery by David Swingle, M.D. on the evening of May 21, 1991. He underwent cervical laminectomies at the levels of C-2/C-6, inclusive. His quadriplegia was determined to have been caused by spinal cord compression by an epidural abscess, which subsequently grew out cultures positive for staph aureus.

19. Pathological study of the surgical specimens, including bone chips, proved the diagnosis to be cervical epidural abscess.

20. The patient remanded quadriplegic and was discharged from MCP, and then admitted to the Magee Rehabilitation Hospital, where he was confined until discharged on June 3, 1991.

21. On June 3, 1991, Mr. Pappas was re-admitted to MCP, where he was confined until discharged on June 28, 1991. During this admission, the patient remained quadriplegic as a result of spinal compression caused by an epidural abscess. The patient was admitted because of fever thought to be due to urinary tract infection, and for workup for the possibility of spinal meningitis.

22. Basile Pappas remains permanently and irreversibly paralyzed in his lower extremities, with loss of

bowel and bladder and sexual function; and remains significantly paralyzed in his upper extremities, with only return of partial upper extremity function. Mr. Pappas' upper extremities are tight, and spastic, consistent with major neurologic injury.

23. The negligence of the defendant David S. Asbel, D.O. consisted of the following:

a. Failing to do a complete and thorough neurological examination of Mr. Pappas in his office on May 20, 1991, given the signs and symptoms of plaintiff's presentation and history;

b. Failing to diagnose and recognize neurologic deficits affecting plaintiff's body on May 20, 1991;

c. Failing to take a complete and thorough history from Mr. Pappas on May 20, 1991;

d. Failing to admit Mr. Pappas to the hospital on an urgent basis on May 20, 1991, for immediate myelogram, CAT Scans, MRI's, neurological and neurosurgical consultations, and immediate surgery, all for a presumptive diagnosis of spinal cord compression, probably related to an epidural abscess;

e. Failing to inform and advise the patient on May 20th of the serious implications of his presentation, and of the need for urgent and emergent hospitalization with probable need for surgery;

f. Injecting the patient's neck with steroid preparations, all in contravention to what medical standards would have dictated at the time, given the neurologic components of patient's signs and symptoms;

g. Breach of sterile technique in the injection previously described, as a result of which defendant did, or may have, pushed staph infection into the patient's spinal canal;

h. Completely reassuring the patient concerning the nature of the condition causing his signs and symptoms, by affirmatively stating to the patient that he had somatic dysfunction, which would respond favorable to the injection, and to medications prescribed on that visit;

i. Giving the patient completely inadequate instructions concerning what to look for in the aftermath of the office visit, especially as those instructions should have alerted the patient to watch for progression of neurologic signs and symptoms, and other changes in his condition;

j. Failing, once again, to respond adequately to patient's signs and symptoms and continuing deterioration, on the occasion when Mrs. Pappas called him during the evening of May 20, 1991, and reported continuation of extremity weakness, numbness, and neurologic deterioration;

k. Failure thereafter to respond adequately, and to diagnose the patient as having probable spinal cord compression, based upon information already known to the patient, and information communicated to him prior to patient's hospitalization and 'Haverford Community Hospital;

l. Abandoning the patient, by refusing to intervene in response to telephone communications from Mrs.

Pappas, which communicated information should have caused the defendant to realize the patient's need for prompt, urgent hospitalization, and for immediate workup for presumed spinal cord compression;

m. Failing to respond adequately when contacted by personnel of the Haverford Community Hospital, and to make immediate steps to have the patient admitted to a hospital competent and experienced to perform the necessary surgery;

n. Allowing plaintiff's spinal cord compression to go unrecognized and undiagnosed, during all of which time the condition was caused to deteriorate progressively, with the result that the patient became permanently quadriplegic because of lack of proper medical and surgical intervention;

o. Prescribing medications to the patient on May 20th, which were contra-indicated.

24. The negligence of the defendant Haverford Community Hospital, acting through its authorized agents, servants and employees, including emergency room personnel, house physicians, medical staff members, nurses, radiologists, and other types of healthcare professionals, consisted of the following:

a. Failing to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. Delaying inordinately in transferring the patient, keeping him at the Haverford Community Hospital during which time his spinal cord compression

continued, with resulting permanent damage to the patient's spinal cord.

25. At all times material to this Complaint, the plaintiffs acted with due care and were not contributorily negligent.

COUNT I – BASILE PAPPAS v. DEFENDANTS

26. Plaintiff incorporates by reference each and every paragraph of this Complaint which has preceded this Count, as if each such paragraph were individually set forth within this Count.

27. As a result of the negligence of the defendants, the plaintiff has sustained quadriplegia, loss of the function of his extremities, loss of bowel and bladder function, loss of sexual capacity, is a complete invalid, requiring constant care and attention for the most basic bodily needs; has suffered extreme mental illness and anxiety, including depression, fear, sadness, loss of interest in life's pleasures and activities, and related psychic damage; and has suffered loss of enjoyment of life, has required multiple hospitalizations and medical and surgical treatments, and is subject to ongoing need for medical and surgical therapies throughout his life, together with constant care for his debilitated condition of mind and body.

28. As a result of the negligence of the defendants, the plaintiff has and will continue to sustain for the rest of his life great bodily pain and suffering.

29. As a result of the negligence of the defendants, the plaintiff has and will forever suffer mental illness, depression and anxiety.

30. As a result of the negligence of the defendants, the plaintiff has and will continue to incur large medical and related bills for ongoing care and therapy.

31. As a result of the negligence of the defendants, the plaintiff has lost his livelihood, his earnings, and his earning capacity, with grave economic and financial implications.

32. As a result of the negligence of the defendants, the plaintiff has suffered the loss of the enjoyment of his life, inconvenience, disruption of his daily habits and pursuits, and permanent loss of happiness.

33. As a result of the negligence of the defendants, the plaintiff has suffered permanent embarrassment, humiliation, and scarring of mind and body.

34. As a result of the negligence of the defendants, the plaintiff is now totally dependent upon his wife and others.

WHEREFORE, plaintiff claims judgment against each defendant in a sum in excess of $20,000.00, exclusive of interest and costs.

COUNT II – THEODORA PAPPAS v. DEFENDANTS

35. Plaintiff incorporates by reference all of the preceding paragraphs of this Complaint, including those of Count I, as if each such paragraph were individually set forth within this Count.

36. As a result of the negligence of the defendants, the plaintiff has and will continue to suffer a loss of consortium, and has and will continue to suffer a disruption of her daily habits and pursuits, and alteration in her own lifestyle, and will need to render constant care and attention to her debilitated husband.

WHEREFORE, plaintiff demands judgment against each defendant in a sum in excess of $20,000.00, exclusive of interest and costs.

BEASLEY, CASEY, COLLERAN, ERBSTEIN, THISTLE & KLINE

BY: /s/ James E. Colleran
JAMES E. COLLERAN, ESQUIRE
Attorney for Plaintiffs

COMMONWEALTH OF PENNSYLVANIA : SS
COUNTY OF PHILADELPHIA :

Basile Pappas, being duly sworn according to law, deposes and says that he is the plaintiff herein and that the facts set forth in the foregoing pleading are true and correct to the best of his knowledge, information and belief.

x Basile Pappas
BASILE PAPPAS

Sworn to and Subscribed :

Before me this 12th day :

Of March A.D., 1992 :

/s/ Anita S. Markovitz
Notary Public

Notary Seal
Anita S. Markovic, Notary Public
Philadelphia, Philadelphia County
My Commission Expires Feb. 15, 1993

BASILE PAPPAS and THEODORA PAPPAS, his wife	:	DELAWARE COUNTY COURT OF COMMON PLEAS
v.	:	CIVIL ACTION – LAW
DAVID S. ASBEL, D.O.,	:	NO. 92-3903
Defendant	:	
and	:	
HAVERFORD COMMUNITY HOSPITAL,	:	JURY TRIAL DEMANDED
Defendant and Third-Party Plaintiff	:	
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. 980 Jolly Road Blue Bell, PA 19422	:	
Third-Party Defendant	:	

THIRD-PARTY COMPLAINT

1. Plaintiffs, Basile Pappas and Theodora Pappas, have filed a Complaint against defendants, David S. Asbel, D.O. and Haverford Community Hospital, a copy of which is attached hereto and marked Exhibit A.

2. Defendant, third-party plaintiff, Haverford Community Hospital, has filed an Answer and New Matter Pursuant to Pa.R.C.P. 2252(d) to said Complaint, copy of which is attached hereto and marked Exhibit B.

3. Third-party defendant, United States Healthcare Systems of Pennsylvania, Inc. is a duly organized Pennsylvania corporation doing business in the Commonwealth of Pennsylvania and in Delaware County.

4. Third-party defendant operates and controls a health maintenance organization known as Health Maintenance Organization of Pennsylvania (HMO-PA).

5. Husband-plaintiff was, at all times pertinent hereto, a subscriber in HMO-PA.

6. Third-party plaintiff incorporates by reference the allegations of paragraph 24 of plaintiffs' Complaint, and its Answer thereto as if fully set forth in their entirety.

7. HMO-PA refused to authorize transfer of husband-plaintiff to a hospital selected by physicians at Haverford Community Hospital as being able to minister to husband-plaintiff's condition.

8. If plaintiffs receive an award or verdict in their favor based on the allegations of paragraph 24 of the Complaint, then, in such event, third-party defendant is liable over to third-party plaintiff for the amount of said award or verdict.

WHEREFORE, defendant and third-party plaintiff, Haverford Community Hospital, demands judgment against third-party defendant, United States Healthcare Systems of Pennsylvania, Inc., for all sums adjudged

against Haverford Community Hospital in favor of plaintiffs.

MASTERSON, BRAUMFELD,
HIMSWORTH & MAGUIRE

BY: /s/ Jerome E. Ornsteen
Jerome E. Ornsteen
Attorneys for Defendant
Haverford Community
Hospital

VERIFICATION

I hereby verify and state that I am associated with the law firm of Masterson, Braunfeld, Himsworth & Maguire, attorneys for Haverford Community Hospital, one of the defendants in this matter, that I am authorized to take this Verification on its behalf, that the facts set forth in the foregoing Third-Party Complaint are true and correct to the best of my knowledge, information and belief, and that I understand that these facts are subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

/s/ Jerome E. Ornsteen
JEROME E. ORNSTEEN

DATED: April 6, 1992

[J-97-97]

IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

BASILE PAPPAS AND THEODORA PAPPAS, H/W V. DAVID ASBEL, D.O. AND PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),	:	No. 98 ED Appeal Dkt. 96
Appellees	:	Petition for Reconsideration/ Reargument
v.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,	:	
Appellant	:	

ORDER

PER CURIAM:

AND NOW, this 12th day of February, 1999, Appellant's Petition for Reconsideration/Reargument is hereby DENIED.

TRUE COPY FROM RECORD

Attest FEB 12, 1999

/s/ Patricia Johnson
Patricia Johnson, Chief Clerk
Supreme Court of Pennsylvania,
Eastern District

Supreme Court, U.S.
FILED
JUL 14 1999
OFFICE OF THE CLERK

No. 98-1836

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE PENNSYLVANIA SUPREME COURT

RESPONDENTS' BRIEF IN OPPOSITION

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

153939

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

COUNTERSTATEMENT OF QUESTIONS PRESENTED

Whether your Honorable Court has jurisdiction to review the decision of the Pennsylvania Supreme Court, which affirmed the order of the Pennsylvania Superior Court reversing the trial court's judgment and remanding for further proceedings on the merits of the claim?

In enacting ERISA, 29 U.S.C. § 1001, *et seq.* (1990), did Congress intend to supplant the states' traditional roles of regulating health care and enforcing common law tort rights, such that claims that a health maintenance organization was negligent in providing and arranging for medical care are preempted by § 514(a) of the statute?

STATEMENT PURSUANT TO RULES 14.1(b) AND 29.6

The petition accurately lists the parties to the proceedings.

Pennsylvania Hospital Insurance Corporation ("PHICO") is a subsidiary of PHICO Group, Inc., which is owned in its entirety by the Health Alliance of Pennsylvania.

The Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") is a statutorily created executive agency of the Commonwealth.

TABLE OF CONTENTS

	Page
Counterstatement of Questions Presented	i
Statement Pursuant to Rules 14.1(b) and 29.6	ii
Table of Contents	iii
Table of Cited Authorities	iv
Statement of Jurisdiction	1
Counterstatement of the Case	1
A. Factual Background	1
B. Procedural History	1
Reasons for Denying the Writ	4
I. Your Honorable Court Does Not Have Jurisdiction To Review This Case: The Order Presented By Petitioner Is Not A Final Order.	4
II. There Is No Conflict With Your Court's Decisions Construing Section 514(a) Of ERISA.	6
III. There Is No Conflict With Decisions Of The Third Circuit Or Other Courts Of Appeals.	8
IV. Your Court Has Given Clear Direction To The Lower Courts In This Important Area Of Law.	11
Conclusion	13

TABLE OF CITED AUTHORITIES

Page

Cases:

Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003 (9th Cir. 1998) 8

California Div. of Labor Standards Enforcement v. Dillingham, 519 U.S. 316 (1997) ... 3, 6, 8, 9, 11, 13

Cannon v. Group Health Serv., 77 F.3d 1270 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996) 9

Cipollone v. Liggett Group, 505 U.S. 504 (1992) . 12, 13

Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975) 5

Crum v. Health Alliance-Midwest, Inc., No. 98-CV-2241, 1999 U.S Lexis 6469 (C.D. Ill. May 6, 1999) 11

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997) 3, 6, 11, 13

Dukes v. U.S. Healthcare, 57 F.3d 350 (3rd Cir.), *cert. denied*, 516 U.S. 1009 (1995) 9, 10

Dykema v. King, 959 F. Supp. 736 (D.S.C. 1997) . 12

Englehardt v. Paul Revere Life Ins. Co., 139 F.3d 1346 (11th Cir. 1998) 8

Cited Authorities

	Page
Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996)	8, 9
Jefferson v. City of Tarrant, 522 U.S. 75 (1997)	5
Market Street Rail Co. v. Railroad Comm'n., 324 U.S. 548 (1945)	5
Moreno v. Health Partners Health Plan, 4 F. Supp. 2d 888 (D. Ariz. 1998)	11, 12
Nascimento v. Harvard Community Health Plan, No. 94-2543, 1997 Mass. Super. Lexis 166 (Mass. Super. Sept. 26, 1997)	12
Nealy v. U.S. Healthcare, 93 N.Y.2d 219 (1999)	12
New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)	*passim*
Painter v. Golden Rule Ins. Co., 121 F.3d 436 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1516 (1998)	8
Pappas v. Asbel, 675 A.2d 711 (Pa. Super. 1996)	3
Pappas v. Asbel, 724 A.2d 889 (Pa. 1998)	3
Parrino v. FHP Healthcare, 146 F.3d 699 (9th Cir.), *cert. denied*, 119 S. Ct. 510 (1998)	9

Cited Authorities

Page

Phommyvong v. Muniz, No. 3:98-CV-0070-L, 1999 U.S. Lexis 3101 (N.D. Tex. March 11, 1999) ... 11

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 8

Prudential Ins. Co. of America v. Doe, No. 94-CV-1153, 1999 U.S. Lexis 5635 (E.D. Mo. March 31, 1999) 11

Radio Station WOW, Inc. v. Johnson, 326 U.S. 120 (1945) 4

Kay v. Value Behavioral Health, Inc., 967 F. Supp. 417 (D. Nev. 1997) 12

Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) 8

Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196 (1st Cir. 1997), *cert. denied*, 118 S. Ct. 1512 (1998) 8

Cited Authorities

Page

Statutes:

28 U.S.C. § 1257 1

28 U.S.C. § 1257(a) 4

29 U.S.C. § 1001, *et seq.* (1990) ..... i, 2

Section 502(a) of Employee Retirement Income Security Act, 29 U.S.C. § 1132(a) 8, 10

Section 514(a) of Employee Retirement Income Security Act, 29 U.S.C. § 1144(a) ..... *passim*

Other Authorities:

R. Charrow and L. Greenlees, *ERISA Pre-Emption — A Law in Search of a Doctrine*, Health L. Dig., March 1999 at 14 12

K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. on Reg. 255 (1996) 11

STATEMENT OF JURISDICTION

Petitioners have invoked the jurisdiction of your Honorable Court pursuant to 28 U.S.C. § 1257.

Respondents respectfully suggest that the jurisdiction provided to your Honorable Court under Article III of the Constitution and 28 U.S.C. § 1257 does not obtain in this case. The effect of the order of the Pennsylvania Supreme Court affirming the order of the Superior Court of Pennsylvania is the remand of the cause to the trial court for further proceedings on the merits of the claim. The decision of the Pennsylvania Supreme Court is, therefore, not final and not within the scope of your Honorable Court's jurisdiction.

COUNTERSTATEMENT OF THE CASE

A. Factual Background

The opinion of the Pennsylvania Supreme Court accurately sets forth the factual background.

B. Procedural History

Plaintiffs below, Basile and Theodora Pappas, filed a complaint against David Asbel, D.O. and Haverford Community Hospital ("Haverford"), alleging, *inter alia*, that these defendants were negligent in failing to timely diagnose and treat Mr. Pappas' spinal cord compression. App. 47a-58a. Haverford filed an Original Joinder Complaint, joining United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") as an additional defendant. App. 59a-61a. Haverford alleged that "HMO-PA refused to authorize

transfer of husband/plaintiff to a hospital selected by physicians at Haverford Community Hospital" App. 60a, para. 7. Furthermore, by incorporation of paragraph 24 of plaintiffs' complaint (App. 60a, para. 6), Haverford alleged that HMO-PA negligently:

> a. fail[ed] to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;
>
> b. delay[ed] inordinately in transferring the patient, keeping him at the Haverford Community Hospital during which time his spinal cord compression continued with resultant damage to the patient's spinal cord. App. 54a-55a.

At the close of discovery, U.S. Healthcare filed a Motion for Summary Judgment, claiming that Haverford's Joinder Complaint must be dismissed under the preemption provisions of the Federal Employee Retirement Income Security Act of 1975 (ERISA), 29 U.S.C. § 1001, *et seq.* (1990). The trial court granted U.S. Healthcare's Motion for Summary Judgment, finding that all of Haverford's claims against U.S. Healthcare fell within the confines of administration of an employee benefit plan, and therefore, were barred under the ERISA preemption provision. App. 41a. Ultimately, a settlement agreement was reached among the original parties, and the Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") were substituted for Haverford as the real parties in interest. App. 45a-46a.

Upon appeal, the Superior Court of Pennsylvania reversed the trial court's decision, finding that Haverford's claims against U.S. Healthcare were state law negligence claims, and thus had no impact on the benefit plan in question. *Pappas v. Asbel*, 675 A.2d 711, 717 (Pa. Super. 1996); App. 18a-33a. In reaching that decision, the court was guided by *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The court remanded the matter to the trial court for further proceedings on the merits of the claim.

The Pennsylvania Supreme Court considered this case for more than one and one half years before affirming the order of the Superior Court. *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998); App. 1a-16a. The court's decision to affirm the judgment of the Superior Court rendered in favor of PHICO and the CAT Fund was unanimous in its result. The decision of the court addresses and resolves the question whether claims of medical negligence are preempted by ERISA. In resolving that question, the court's opinion recognizes that your Honorable Court has yet to address directly the issue whether particular medical malpractice claims against an HMO "relate to" an ERISA plan. App. 6a. The Pennsylvania Supreme Court quite properly followed the direction of your Court in *Travelers, Id.*, as well as *California Div. of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316 (1997) and most recently, *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997). The Pennsylvania Supreme Court also remanded the case for further proceedings on the merits of the claim and noted that the threshold issue of liability had yet to be resolved.

REASONS FOR DENYING THE WRIT

I.

YOUR HONORABLE COURT DOES NOT HAVE JURISDICTION TO REVIEW THIS CASE: THE ORDER PRESENTED BY PETITIONER IS NOT A FINAL ORDER.

The power of your Honorable Court to review the decisions rendered by state courts is limited to "final judgments or decrees rendered by the highest court of a state in which a decision could be had." 28 U.S.C. § 1257(a). The consequence of the Pennsylvania Supreme Court's decision is remand of the cause for further proceedings on respondents' state law claims. The outcome of those proceedings could moot the question your Court is being petitioned to decide.

The Pennsylvania Supreme Court did not render a "final judgment". It affirmed the order of the Superior Court of Pennsylvania, which reversed and remanded for further proceedings the judgment of the trial court. App. 13a; 18a-19a. Indeed, the order itself contemplates further proceedings: "it is now left for the fact finder to determine if U.S. Healthcare's defenses to the negligence claims are valid." App. 13a, n.7.

Your Court has expressly recognized that the finality requirement "is not one of those technicalities to be easily scorned." *Radio Station WOW, Inc. v. Johnson*, 326 U.S. 120, 124 (1945). In order to be final and reviewable, a state court decision "must be subject to no further review or correction in any other State tribunal; it must also be final

as an effective determination of the litigation and not of merely interlocutory or intermediate steps therein." *Market Street Rail Co. v. Railroad Comm'n.*, 324 U.S. 548, 551 (1945). The decision below, remanding the cause for trial on all counts, plainly does not meet this standard. As your Court has observed under similar circumstances, "absent settlement or further dispositive motions, the proceedings on remand will include a trial on the merits of the state law claims." *Jefferson v. City of Tarrant*, 522 U.S. 75, 81 (1997). Here, as in *Tarrant*, the outcome of the proceedings on remand could moot the federal question presently at issue. And, as in *Tarrant*, if the federal question does not become moot, petitioner will be free to seek your Court's review at the end of the state court proceedings. *See* 522 U.S. at 77-78.

Seeking to obtain your Court's jurisdiction, petitioner invokes *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 482-483 (1975). Therein, your Court describes situations in which it has treated the decision of a state court on a federal issue as a final judgment. One of those instances which arguably may apply here, is when a petitioner "might prevail on the merits on non-federal grounds, thus rendering unnecessary review of the federal issue by this Court, and where reversal of the state court on the federal issue would be preclusive of any further litigation on the relevant cause of action." *Id.* Importantly, however, this exception applies when "a refusal immediately to review the state court decision might seriously erode federal policy". *Id.* That is not the case here. As pointed out more fully, *infra*, the decision of the Pennsylvania Supreme Court is in accordance with your Court's decisions, and thus consistent with federal policy.

II.

THERE IS NO CONFLICT WITH YOUR COURT'S DECISIONS CONSTRUING SECTION 514(a) OF ERISA.

Your Honorable Court has yet to confront squarely the issue whether medical negligence claims against an HMO are preempted by § 514(a) of ERISA. Recognizing this, the Pennsylvania Supreme Court correctly followed the direction prescribed by your Court in *Travelers, Dillingham*, and the more recent *DeBuono*. Contrary to U.S. Healthcare's assertion, the court below did not "anticipate" the overruling of precedent, but instead, applied your Court's endorsement to look to the "objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." App. 8a, citing *Travelers*. Importantly, this is the explicit directive your Court issued in *DeBuono*, 520 U.S. at 813-814.

U.S. Healthcare attempts to assign error to the Pennsylvania Supreme Court's reference, in its opinion, to Mr. Justice Scalia's concurrence in *Dillingham*. In doing so, however, U.S. Healthcare ignores the court's reliance on the *DeBuono* decision, in which the majority quotes from that same concurrence. *DeBuono*, 520 U.S. at 813, n.7.

The core of petitioner's argument in the courts below, as well as to your Court, is that Haverford's claim against it "arises from and directly relates to" the administration of benefits under an ERISA governed health plan, thus falling within the preemptive reach of § 514(a). Petition at 7. This argument falls short; by incorporating paragraph 24 of the plaintiffs' complaint, Haverford asserted that U.S.

Healthcare failed to transfer the patient to a hospital capable of treating his acute condition promptly and delayed in transferring the patient, thus increasing the injury to the patient. These allegations are common law tort allegations regarding the quality of the medical care provided. The institutions authorized by U.S. Healthcare to accept Mr. Pappas were not capable of accepting him with the speed necessary to treat his rapidly deteriorating condition, and U.S. Healthcare's medical reviewer knew or should have known it. Therefore, U.S. Healthcare was negligent in the care it provided to Mr. Pappas.

Both of Pennsylvania's appellate courts expressly recognized that the claims made against petitioner are common law tort claims. "Appellants do not seek benefits denied, because Mr. Pappas was transferred to a hospital capable of supplying the needed services; they do not seek to challenge the administration of the Plan, again because there is no complaint that USHC did not perform its duties." App. 31a. "Claims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care." App. 11a. Relying on *Travelers*, the Pennsylvania Supreme Court further comments "it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care." App. 11a-12a.

III.

THERE IS NO CONFLICT WITH DECISIONS OF THE THIRD CIRCUIT OR OTHER COURTS OF APPEALS.

U.S. Healthcare cites to seven decisions of the United States Courts of Appeals issued subsequent to *Travelers* and *Dillingham* for the proposition that the court below improperly ignored federal appellate holdings that ERISA preempts medical malpractice claims. Those seven decisions are freely distinguishable.

Bast v. Prudential Ins. Co. of Am., 150 F.3d 1003 (9th Cir. 1998); *Englehardt v. Paul Revere Life Ins. Co.*, 139 F.3d 1346 (11th Cir. 1998); *Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997), *cert. denied*, 118 S. Ct. 1512 (1998); and *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997), *cert. denied*, 118 S. Ct. 1516 (1998), all involved plaintiffs' claims which came within the scope of the civil enforcement provisions set forth in § 502(a)(1)(B) of ERISA. Thus, the United States Circuit Courts all determined that those claims were completely preempted. Where a claim is completely preempted under § 502(a), it is necessarily preempted under § 514(a). *Rice v. Panchal*, 65 F.3d 637, 646, n.10 (7th Cir. 1995), citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). As discussed more completely, *infra*, the issue herein is whether the malpractice claims were preempted by § 514(a).

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996), does not discuss or even cite to *Travelers*. And although the court did find that the plaintiff's claim

that her HMO was vicariously liable for her doctor's negligence "related to" her benefit plan and was preempted, part of the reason for that conclusion was that the plan provided a higher level of benefits if participants sought treatment from that physician, necessitating referral to the plan. *Id.* at 1493.

Likewise, *Cannon v. Group Health Serv.*, 77 F.3d 1270 (10th Cir.), *cert. denied*, 519 U.S. 816 (1996), does not mention *Travelers*. The issue in *Cannon*, however, was whether ERISA may preempt state common law claims when no alternative remedy is possible. The court stated, and the plaintiff did not dispute, that the claims at issue were claims asserting improper processing of benefits, thus preempted under ERISA. *Id.* at 1273-1274.

Similarly, *Parrino v. FHP Healthcare*, 146 F.3d 699 (9th Cir.), *cert. denied*, 119 S. Ct. 510 (1998), arose from inappropriate processing of a claim for plan benefits. The court held the claim preempted under § 514(a). In doing so, the court noted that ERISA preempts "state laws that mandate[ ] employee benefit structures or their administration." *Id.* at 705, citing *Travelers*.

Careful examination of the above decisions distinguishes them from the instant matter, where the claim is that U.S. Healthcare was negligent in arranging for and providing medical care to Mr. Pappas. Consequently, the court below did not err in suggesting that an absence of post *Travelers* and post *Dillingham* federal appellate decisions supported its ruling.

Analysis of the Third Circuit's decision in *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3rd Cir.), *cert. denied*, 516

U.S. 1009 (1995), correspondingly reveals the flaw in petitioner's argument. In *Dukes* the issue, again, was whether the plaintiffs' claims came within the scope of the civil enforcement provisions set forth in § 502(a)(1)(B) of ERISA, thus permitting their removal to federal court. Because the plaintiffs were not attempting to "recover benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan", but instead attacked the quality of the benefits they received, the Third Circuit found that removal was improper. In reaching that outcome, the court began its analysis with statutory construction, as directed by *Travelers*. The court resolved that quality control of benefits "is a field traditionally occupied by state regulation and . . . interpret[ed] the silence of Congress as reflecting an intent that it remain such." *Dukes*, 57 F.3d at 357. In particular, the court concluded that its holding leaves "open for resolution by the state courts" whether negligence claims, such as those asserted herein, are preempted under § 514(a) of ERISA. *Id.*

Because it is not an issue in this case, the ruling of the Pennsylvania Supreme Court does not touch on the complete-preemption exception of those state laws which fall within the civil enforcement provision of § 502. The court correctly addressed the "relate to" language of § 514 which is at issue here, and which, pointedly, was not resolved by *Dukes*. Thus, there is no conflict between the Pennsylvania Supreme Court and the United States Court of Appeals for the Third Circuit.

IV.

YOUR COURT HAS GIVEN CLEAR DIRECTION TO THE LOWER COURTS IN THIS IMPORTANT AREA OF LAW.

In the past, lower court decisions with respect to the extent of ERISA § 514(a) preemption have varied markedly and incompatibly. Notably, nearly all inconsistencies occurred prior to the decisions handed down by your Honorable Court in *Travelers*, *DeBuono* and *Dillingham*. Importantly, however, as one author has recognized, *Travelers* "provides much needed guidance for courts asked to identify the line delimiting state laws that Congress intended to preempt . . ." K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. on Reg. 255, 290 (1996).

Travelers' influence is now emerging in decisions of other lower courts, limiting ERISA preemption of state law tort claims. These courts have applied *Travelers* and its progeny to come to a more functional definition of "relate to". *See, for example, Crum v. Health Alliance-Midwest, Inc.*, No. 98-CV-2241, 1999 U.S Lexis 6469, *9 (C.D. Ill. May 6, 1999) (noting that a claim for failure to diagnose myocardial infarction would not be preempted under § 514(a)); *Prudential Ins. Co. of America v. Doe*, No. 94-CV-1153, 1999 U.S. Lexis 5635, *34 (E.D. Mo. March 31, 1999) (determining that claims for emotional distress and invasion of privacy are not preempted); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 U.S. Lexis 3101, *10 (N.D. Tex. March 11, 1999) (concluding ERISA preemption does not apply to claims based upon quality of care received); *Moreno v. Health Partners Health Plan*, 4

F. Supp. 2d 888, 893 (D. Ariz. 1998) (finding "no relation between an action for medical malpractice and the recovery of benefits or the clarification of rights to future benefits under an ERISA plan."); *Ray v. Value Behavioral Health, Inc.*, 967 F. Supp. 417, 423 (D. Nev. 1997) (finding claims for negligence, invasion of privacy and infliction of emotional distress are "exactly the sort of generally applicable personal injury laws that § 514 of ERISA does not preempt."); *Dykema v. King*, 959 F. Supp. 736, 739 (D.S.C. 1997) (agreeing that a claim of direct liability for failure to diagnose pulmonary embolism does not "relate to" an ERISA plan); *Nascimento v. Harvard Community Health Plan*, No. 94-2543, 1997 Mass. Super. Lexis 166, *27 (Mass. Super. Sept. 26, 1997) (holding that the provisions of ERISA do not preempt a claim for failure to provide bone marrow transplantation therapy); *Nealy v. U.S. Healthcare*, 93 N.Y.2d 219-220 (1999) (noting claims for failure to take reasonable steps to provide for patient's timely treatment by specialist do not "relate to" the administration of an ERISA plan). Each of these decisions is compatible with "the general tenor of recent [Supreme] Court cases that reemphasize the strength and vitality of the presumption against ERISA pre-emption of laws of general application." R. Charrow and L. Greenlees, *ERISA Pre-Emption — A Law in Search of a Doctrine*, Health L. Dig., March 1999 at 14.

In like manner, the Pennsylvania Supreme Court, in reaching its decision, applied the direction set forth in *Travelers*, as well as other decisions of your Court. First, the court heeded the caution to "assum[e] that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless it [is] the clear and manifest purpose of Congress." App. 5a, citing *Cipollone v. Liggett Group*,

505 U.S. 504, 516 (1992). Next, the court turned to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." App. 8a, citing 514 U.S. at 656. Simply put, the statute contains no suggestion that it was intended to displace the states' traditional roles of regulating health care and countering negligent patient care. The Pennsylvania Supreme Court properly followed your Court's holdings and determined that Haverford's claim did not "relate to" the administration of an ERISA plan.

CONCLUSION

There is no reason for your Honorable Court to intervene in this matter. The decision of the Pennsylvania Supreme Court is not a final judgment. Moreover, it is consistent with your Honorable Court's holdings in *Travelers, DeBuono* and *Dillingham*. The petition should be denied.

Respectfully submitted,

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

(3)

Supreme Court, U.S.
FILED
JUL 28 1999
OFFICE OF THE CLERK

No. 98-1836

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

---

REPLY BRIEF FOR PETITIONER

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

158

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

I. THE DECISION BELOW IS A "FINAL JUDGMENT" THAT THIS COURT HAS JURISDICTION TO REVIEW 1

II. THE DECISION BELOW CONFLICTS WITH NUMEROUS DECISIONS OF THE COURTS OF APPEALS AND THIS COURT 6

CONCLUSION 10

TABLE OF AUTHORITIES

Page(s)

Cases

Bast v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998) 6

Belknap v. *Hale*, 463 U.S. 491 (1983) 4, 5

Cohen v. *Beneficial Indus. Loan Corp.*, 337 U.S. 541 (1949) 1

Corcoran v. *United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992) 10

Cox Broad. Corp. v. *Cohn*, 420 U.S. 469 (1975) . . . . *passim*

Dukes v. *U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995) 6

Engelhardt v. *Paul Revere Life Ins. Co.*, 139 F.3d 1346 (11th Cir. 1998) 6

Fort Wayne Books, Inc. v. *Indiana*, 489 U.S. 46 (1989) . . . 4

Goodyear Atomic Corp. v. *Miller*, 486 U.S. 174 (1988) 3, 4, 5

Hohn v. *United States*, 524 U.S. 236 (1998) 9

Hudson Distribs., Inc. v. *Eli Lilly & Co.*, 377 U.S. 386 (1964) 4

Huss v. *Green Spring Health Servs., Inc.*, 1999 U.S. Dist. LEXIS 5101 (E.D. Pa. April 16, 1999) . . . 6

INS v. *Cardoza-Fonseca*, 480 U.S. 421 (1987) 10

Jefferson v. *City of Tarrant*, 522 U.S. 75 (1997) 5

Local No. 438 Constr. & Gen. Laborers' Union v. *Curry*, 371 U.S. 542 (1963) 4

Market Street Ry. Co. v. *Railroad Comm'n*, 324 U.S. 548 (1945) 5

Mercantile Nat'l Bank v. *Langdeau*, 371 U.S. 555 (1963) . . 4

TABLE OF AUTHORITIES - Continued

Page(s)

Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724 (1985) 8

Miami Herald Publ'g Co. v. *Tornillo*, 418 U.S. 241 (1974) . 4

Mississippi Power & Light Co. v. *Mississippi*, 487 U.S. 354 (1988) 3, 4

National Socialist Party of Am. v. *Skokie*, 432 U.S. 43 (1977) 4

New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645 (1995) . . . . . *passim*

Organization for a Better Austin v. *Keefe*, 402 U.S. 415 (1971) 4

Painter v. *Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir.1997), cert. denied, 523 U.S. 1074 (1998) 6

Pilot Life Ins. Co. v. *Dedeaux*, 481 U.S. 41 (1987) 8, 9

Radio Station WOW, Inc. v. *Johnson*, 326 U.S. 120 (1945) 5

Shaffer v. *Heitner*, 433 U.S. 186 (1977) 4

Shaw v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983) 2, 8

Southland Corp. v. *Keating*, 465 U.S. 1 (1984) 4

Turner v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997), cert. denied, 523 U.S. 1072 (1998) 6

Statutes

29 U.S.C. § 1001(a) 2, 3

Section 502(a) of ERISA, 29 U.S.C. § 1132(a) 6, 7

Section 514 of ERISA, 29 U.S.C. § 1144 9

TABLE OF AUTHORITIES - Continued

Page(s)

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) . . . . . *passim*

Miscellaneous

120 CONG. REC. 29197 (1974) 2

145 CONG. REC. S8524 (daily ed. July 14, 1999) 9, 10

Patients' Bill of Rights Act of 1999 (S. 1344) 9

H.R. REP. NO. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639 2

S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838 2

William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451 (1991) 3

Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 304 (1996) 8

Petitioners' Reply Brief, 1997 WL 471826, *Jefferson v. City of Tarrant*, No. 96-957 (U.S. Aug. 15, 1997) . 5

REPLY BRIEF FOR PETITIONER

As we showed in the petition, lower courts and commentators alike have observed that ERISA preemption of medical malpractice actions against HMOs is a difficult subject that has yielded inconsistent decisions and cries out for clarification by this Court. Yet respondents join the Supreme Court of Pennsylvania in asserting that the issue is really quite easy, because this Court deprived all its earlier case law of any precedential force in one fell swoop, without overruling it, when it decided the line of ERISA preemption cases that began with *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). That facile assertion leads respondents into not just one error, but two: to try to defeat jurisdiction, they deny that there is even a possibility that "refusal immediately to review the state court decision might seriously erode federal policy" (*Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 483 (1975)); and, to try to defeat review on the merits of the remarkable decision below, they deny that the pre-*Travelers* decisions have any remaining force and that the evident disarray in the circuits really exists. In all of these arguments, respondents are entirely incorrect.

I. THE DECISION BELOW IS A "FINAL JUDGMENT" THAT THIS COURT HAS JURISDICTION TO REVIEW

Respondents claim that this Court lacks jurisdiction to review the decision of the Pennsylvania Supreme Court because further proceedings are pending in state court. Opp. 3. Their argument ignores this Court's teaching that finality is to be given a "practical rather than a technical construction," *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541, 546 (1949), and disregards the vital federal interests threatened by a denial of immediate review.

Immediate review of a decision by the highest court in a state is proper notwithstanding ongoing state-court proceedings if (i) the federal issue in question has been finally decided; (ii) "the party seeking review [in this Court] might prevail on the merits on non-federal grounds [in state court], thus rendering unnecessary review of the federal issue"; (iii) reversal of the state court would preclude further litigation on the cause of action; and (iv) "refusal

immediately to review the state court decision might seriously erode federal policy." *Cox*, 420 U.S. at 482-483.

The first three of those requirements are undisputedly met. The federal question presented — whether Section 514(a) of ERISA preempts state law claims arising from an HMO's alleged negligence in administering benefits under an ERISA-governed health plan — has been finally decided by the highest court in Pennsylvania. Pet. App. 1a-16a. If certiorari is denied, petitioner might prevail in state trial court on nonfederal grounds, such as a finding that petitioner's conduct was not negligent. Reversal of the Pennsylvania Supreme Court's decision that the state law claims against petitioner are not preempted by ERISA would bar prosecution of those causes of action.

Despite respondents' contention to the contrary (at Opp. 3), denying immediate review poses a serious risk of "erod[ing] federal policy." The decision of the Pennsylvania Supreme Court threatens fundamental alteration of the structure and function of a regulatory scheme on which "the continued well-being and security of millions of employees and their dependents" rely. 29 U.S.C. § 1001(a). The ERISA scheme, which reflects a finely wrought compromise among employers, employees, insurers, and providers, demands "uniformity of decision [in order to] help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." H.R. REP. NO. 93-533, at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650; accord S. REP. NO. 93-127, at 35 (1973) (it is "essential to provide for a uniform source of law" to govern ERISA plans in order to avoid the confusion and inefficiency attendant to state regulation), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4871. Congress's decision to mandate application of a uniform, federal body of law to employee benefit plans has been characterized as the "crowning achievement of th[e] legislation * * * round[ing] out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983) (quoting 120 CONG. REC. 29197 (1974) (comments of Representative Dent)).

Delayed review of the decision below — which sanctions direct and indirect state regulation of administration of ERISA plan bene-

fits — could have significant adverse consequences. With the blessing of the Pennsylvania Supreme Court, both individual litigants and state regulators could seek state-law sanctions for alleged misadministration of ERISA plan benefits. ERISA plan administrators, facing exposure to state tort liability and significant uncertainty given inconsistent state and federal preemption decisions (see Pet. 13-18), would have strong incentives to adopt a state-by-state approach to plan administration. The corresponding costs would be passed on to the consumer or lead to rapid and unnecessary depletion of plan assets. See William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 489 n.193 (1991). That chain of events would frustrate the express purpose of ERISA to secure "the soundness and stability of plans with respect to adequate funds to pay promised benefits." 29 U.S.C. § 1001(a).

In similar circumstances, this Court has repeatedly applied *Cox* to grant immediate review. In *Mississippi Power & Light Co.* v. *Mississippi*, 487 U.S. 354 (1988), for example, the Court considered whether a decision by the Federal Energy Regulatory Commission allocating the cost of constructing a nuclear power plant among four utility companies preempted a state regulator from examining the prudence of constructing the plant. *Id.* at 356. The state supreme court had held that a prudence inquiry by state regulators was not preempted and remanded the case to the state regulators to conduct such an inquiry. See *id.* at 368. Despite the pendency of state proceedings, this Court held that the decision below was "final" under *Cox*: "The critical federal question — whether federal law pre-empts such [state regulatory] proceedings while the FERC order remains in effect — has * * * already been answered by the State Supreme Court and its judgment is therefore ripe for review." *Id.* at 370 n.11.

Similarly, in *Goodyear Atomic Corp.* v. *Miller*, 486 U.S. 174 (1988), the Court granted certiorari to decide whether the State of Ohio violated the Supremacy Clause by subjecting a private contractor operating a federally owned nuclear production facility to a state workers' compensation law giving employees higher awards for injuries resulting from a violation of state safety regulations. *Id.* at 176. The Ohio Supreme Court had held that federal law did not preempt Ohio from applying state safety requirements to

nuclear facilities; accordingly, the state industrial commission was ordered to consider the merits of the employee's claim. See *id.* at 177-178. Despite the pendency of those state proceedings, immediate review was granted under *Cox*. As the Court emphasized, leaving the Ohio Supreme Court's decision unreviewed threatened to undermine vital federal policies. *Id.* at 179. The state-court decision "sanction[ed] direct state regulation" of the nuclear facility involved in the case and had "important implications for the regulation of federally owned nuclear production facilities in other States." *Id.* at 179-180.

Mississippi Power & Light and *Goodyear Atomic* are just recent examples of a long line of cases granting immediate review of state-court preemption decisions despite pending state proceedings. In *Southland Corp.* v. *Keating*, 465 U.S. 1, 6-7 (1984), this Court applied *Cox* to review a state-court decision that the Federal Arbitration Act did not preempt state law claims under the California Franchise Investment Law; although the claims had not yet been tried on the merits, this Court recognized the state court's decision as "final." And in *Belknap* v. *Hale*, 463 U.S. 491, 497 n.5 (1983), and *Local No. 438 Construction & General Laborers Union* v. *Curry*, 371 U.S. 542, 549-551 (1963), this Court reviewed state-court decisions regarding the preemptive scope of the National Labor Relations Act even though both state-court decisions contemplated further proceedings below.[1]

Respondents' sole argument about the fourth *Cox* factor is that delayed review poses no risk of "seriously erod[ing] federal policy" because the decision below "is in accordance with your Court's decisions, and thus consistent with federal policy." Opp. 5. That as-

---

[1] The flexible approach to finality ratified in *Cox* and invoked here has also been applied repeatedly in non-preemption contexts. See, *e.g.*, *Fort Wayne Books, Inc.* v. *Indiana*, 489 U.S. 46, 55-57 (1989); *Shaffer* v. *Heitner*, 433 U.S. 186, 195 n.12 (1977); *National Socialist Party of Am.* v. *Skokie*, 432 U.S. 43, 44 (1977); *Miami Herald Publ'g Co.* v. *Tornillo*, 418 U.S. 241, 246-47 & n. 6 (1974); *Organization for a Better Austin* v. *Keefe*, 402 U.S. 415, 418 n.1 (1971); *Hudson Distribs., Inc.* v. *Eli Lilly & Co.*, 377 U.S. 386, 389 (1964); *Mercantile Nat'l Bank* v. *Langdeau*, 371 U.S. 555, 557-58 (1963).

sertion is incorrect (see pp. 8-9, *infra*); more important, it is irrelevant. Respondents' analysis — which would require this Court to decide the merits of a claim ***before*** deciding whether it has jurisdiction to conduct such an inquiry — misses the mark entirely. This Court has granted immediate review on the grounds that an unreviewed state-court decision on preemption "might seriously erode federal policy" in cases in which ***it affirmed the state court's decision***. See, *e.g.*, *Goodyear Atomic*, 486 U.S. at 178-180, 186; *Belknap*, 463 U.S. at 497 n.5, 512. Under *Cox*, the key question is not the correctness of the challenged state-court decision, but instead the potential harm that would result from delaying review. See *Belknap*, 463 U.S. at 497 n.5.[2]

---

[2] Respondents' reliance (at Opp. 3) on *Radio Station WOW, Inc.* v. *Johnson*, 326 U.S. 120 (1945), *Market Street Ry. Co.* v. *Railroad Comm'n*, 324 U.S. 548 (1945), and *Jefferson* v. *City of Tarrant*, 522 U.S. 75 (1997), is misplaced. In *Radio Station WOW*, the Court granted immediate review despite ongoing state-court proceedings because the case fit within the Court's "penumbral" conception of finality. 326 U.S. at 124, 127. *Market Street* simply did not address whether pending state-court proceedings precluded immediate review; the dictum respondents quote from the opinion stands for the unremarkable proposition that a federal question must have been finally decided by the state court in order to be ripe for review, ***not*** for the much broader (and incorrect) principle that a state-court decision is not final if there are ***any*** state-court proceedings yet to come. Cf. *Cox*, 420 U.S. at 477-484. Finally, the analysis in *Jefferson* was restricted to theories of finality that do not apply in this case, and did not extend to the *Cox* test relied on here. See Petitioners' Reply Brief at 3-4, 1997 WL 471826, *Jefferson* v. *City of Tarrant*, No. 96-957 (U.S. Aug. 15, 1997). In *Jefferson*, the Alabama Supreme Court had reversed the state trial court's denial of judgment on the pleadings on the petitioners' federal law claims. See 522 U.S. at 78-80. Reversal by this Court — which would have permitted the petitioners to pursue their federal law claims in state court — would not have been "preclusive of any further litigation on the relevant cause of action." *Cox*, 420 U.S. at 482-483. Thus, the jurisdictional test at issue here could not have applied in *Jefferson*, and that decision has no bearing on this Court's jurisdiction to grant immediate review.

Thus, this case easily satisfies the four *Cox* requirements for immediate review. An exercise of jurisdiction would be an entirely unexceptional application of this Court's longstanding precedent.

II. THE DECISION BELOW CONFLICTS WITH NUMEROUS DECISIONS OF THE COURTS OF APPEALS AND THIS COURT

As petitioner explained in its opening brief (at Pet. 13-18), the Pennsylvania Supreme Court's decision conflicts with numerous holdings by the courts of appeals, including the Third Circuit's holding in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995). Respondents' attempt to distinguish these cases is utterly without merit.

Respondents argue that there is no conflict between the Pennsylvania Supreme Court's decision and *Dukes* because *Dukes* involved the issue of complete preemption for removal purposes under Section 502(a) of ERISA, rather than preemption under Section 514(a), the provision applicable here. But, as respondents themselves concede (at Opp. 8), "[w]here a claim is completely preempted under §502(a), it is necessarily preempted under §514(a)." Thus, the *Dukes* holding that ERISA Section 502(a) preempts negligence claims against HMOs arising from the administration of benefits under a plan is irreconcilable with the Pennsylvania Supreme Court's holding that Section 514(a) does not. As recognized in *Huss* v. *Green Spring Health Services, Inc.*, 1999 U.S. Dist. LEXIS 5101, at *3 (E.D. Pa. April 16, 1999), the decision below creates an unseemly intrastate conflict between state and federal courts in Pennsylvania.

The Pennsylvania Supreme Court's decision also conflicts with numerous other courts of appeals decisions, both pre- and post-*Travelers*. See Pet. 15-17. Contrary to respondents' arguments, *Bast* v. *Prudential Ins. Co. of America*, 150 F.3d 1003 (9th Cir. 1998); *Engelhardt* v. *Paul Revere Life Ins. Co.*, 139 F.3d 1346 (11th Cir. 1998); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997), cert. denied, 523 U.S. 1072 (1998); and *Painter* v. *Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir.1997), cert. denied, 523 U.S. 1074 (1998), all involved merits preemption under Section 514(a), not just complete preemption under Section 502(a). Indeed, the Pennsylvania Supreme Court expressly

acknowledged that these cases applied Section 514(a) to preempt negligence claims arising from the administration of claims for benefits under an ERISA plan, but declared that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." Pet. App. 11a n.5. In any event, for the reasons that petitioner has already explained, the conflict between these cases and the decision below is not lessened simply because they relied on Section 502(a), rather than Section 514(a), to find preemption.

Respondents also contend that these decisions do not conflict with the Pennsylvania Supreme Court's decision because they involved claims based on alleged improper processing of ERISA plan benefits rather than an HMO's "negligen[ce] in arranging for and providing medical care." Opp. 9. Respondents suggest that it is petitioner's failure to give adequate treatment, not its administration of plan benefits, that gives rise to potential liability. But the ***sole*** basis for petitioner's alleged liability in this case is its refusal of coverage for treatment at a non-participating hospital. See Pet. App. 3a-4a, 22a, 37a; 60a.[3] Respondents' suggestion that the negligence claim against petitioner challenges the quality of medical care it arranged rather than its alleged wrongful administration of plan benefits is factually incorrect,[4] and their attempt to distinguish on this basis the holdings of other courts and thereby minimize the sharp conflict in the courts below is accordingly unsound.

---

[3] In their Counterstatement of the Case, respondents assert that petitioner was alleged to have negligently failed to transfer (or delayed in transferring) Basile Pappas to a hospital capable of treating him in a timely manner. Opp. 1-2. This assertion is incorrect. Although Haverford Community Hospital's Third-Party Complaint against petitioner incorporates the Pappases' allegations that the ***Hospital*** and its agents were negligent in failing to transfer Pappas, it contains ***no*** allegations of wrongdoing by petitioner — either directly or by incorporation — other than the allegation that petitioner refused to authorize coverage at a non-participating hospital. Pet. App. 60a, ¶ 7.

[4] The Pappases did not alleged that the participating hospital to which Basile Pappas was ultimately transferred rendered inadequate care to him.

Significantly, respondents concede that, "[i]n the past, lower court decisions with respect to the extent of ERISA §514(a) pre-emption have varied markedly and incompatibly." Opp. 11. They contend, however, that "nearly all" inconsistent rulings preceded *Travelers*, and that *Travelers* gave "clear direction" to the lower courts in this area. *Ibid.* That assertion is belied by their acknowledgment elsewhere that this Court has yet to address the issue of ERISA preemption of negligence claims against HMOs. *Id.* at 6. Moreover, the conflicting rulings cited by petitioner and respondents and the articles cited by both parties[5] further confirm the pressing need for this Court's guidance in this important and oft-litigated area.

Respondents' conclusory argument that there is no conflict between the decision below and this Court's ERISA precedents is no more successful than their attempt to minimize the conflict in the lower courts. Tellingly, they do not even attempt to reconcile the Pennsylvania Supreme Court's decision with this Court's decisions in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987), *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), and *Shaw*, 463 U.S. at 96. Indeed, respondents simply say nothing about *Pilot Life*, *Metropolitan Life*, or *Shaw*, apparently cognizant that any effort to demonstrate fidelity by the Pennsylvania Supreme Court to those decisions would be futile.

In fact, the Pennsylvania Supreme Court freely conceded that it was not following *Pilot Life*, *Metropolitan Life*, or *Shaw*, since it viewed those decisions as "superannuated." Pet. App. 9a. It sought to justify its refusal to abide this Court's precedents by asserting that "*Travelers* and its progeny have thrown the expansive holdings of those earlier cases into question." Pet. App. 10a-11a. But as petitioner has previously noted, this Court has instructed lower courts that they should not anticipate the overruling of this Court's precedents: "Our decisions remain binding precedent until

---

[5] See Pet. 20-21; Opp. 11-12; see also Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 304 (1996) ("[T]he outcomes on the issue of ERISA pre-emption have been inconsistent — indeed, the situation might be characterized as one of utter confusion on the issue.").

we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn* v. *United States*, 524 U.S. 236, 252-253 (1998). In *Pilot Life*, this Court expressly stated that "common law causes of action * * * based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)." 481 U.S. at 48. Here, petitioner made a routine benefits determination that coverage would be provided to Mr. Pappas if he was transferred to any of three designated participating hospitals, but not if he was transferred to Jefferson, which had no contractual relationship with petitioner. *Pilot Life* should have compelled the conclusion that the claims against petitioner for its alleged negligence in administering benefits under Mr. Pappas's ERISA-governed plan were preempted under Section 514(a), and the Pennsylvania Supreme Court's express refusal to follow that decision warrants the grant of certiorari.

The Pennsylvania Supreme Court broadly held that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 11a. That sweeping holding not only conflicts with this Court's precedents, but also rewrites Section 514(a) of ERISA in a manner rejected by Congress. During the recent debate on the Patients' Bill of Rights Act of 1999 (S. 1344), the Senate refused to adopt proposed amendments (Nos. 1246 and 1249) that would have amended Section 514 to allow personal injury suits against HMOs.[6] 145 CONG. REC. S8524, S8527 (daily

---

[6] In pertinent part, these amendments to Section 514 of ERISA would have provided that:

> nothing in this title shall be construed to invalidate, impair, or supersede any cause of action under State law to recover damages resulting from personal injury or for wrongful death against any person
>
> (1) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan; or
>
> (2) that arises out of the arrangement by such person for the

ed. July 14, 1999). Clearly, if Section 514(a) of ERISA already permits the assertion of all manner of negligence claims against HMOs, as held by the court below, the Senate proponents of the amendments cited above would not have deemed it necessary to introduce their amendments. What's more, the Senate's refusal to adopt the amendments provides compelling evidence of the fundamental incompatibility between the evisceration of ERISA preemption effectuated by the Pennsylvania Supreme Court's decision and the intentions of Congress. See *INS* v. *Cardoza-Fonseca*, 480 U.S. 421, 441-443 (1987).

It is the exclusive province of Congress to enact any amendments to Section 514 that might be deemed appropriate. See, *e.g.*, *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1338-1339 (5th Cir.) ("Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA * * *. Our system, of course, allocates this task to Congress, not the courts * * *."), cert. denied, 506 U.S. 1033 (1992). The decision of the Pennsylvania Supreme Court, by sanctioning a radical contraction in the reach of Section 514(a), usurps Congress' role in crafting legislation and thereby necessitates this Court's review.

CONCLUSION

The petition for a writ of certiorari should be granted.

---

provision of such insurance, administrative services, or medical services by other persons.

145 CONG. REC. S8524, S8527 (daily ed. July 14, 1999).

Respectfully submitted.

BURT M. RUBLIN
BALLARD SPAHR ANDREWS &
INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

JULY 1999

Supreme Court, U.S.
FILED
SEP 20 1999
OFFICE OF THE CLERK

No. 98-1836

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

SUPPLEMENTAL BRIEF FOR PETITIONER

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

6PP

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii
CONCLUSION 3

TABLE OF AUTHORITIES

Page(s)

Cases

Danca v. *Private Health Care Systems, Inc.*, ___ F.3d ___, No. 98-1754, 1999 WL 552604 (1st Cir. Aug. 2, 1999) 1,2,3

Hull v. *Fallon*, ___ F.3d ___, No. 99-1036, 1999 WL 637073 (8th Cir. Aug. 23, 1999) 2,3

Kuhl v. *Lincoln National Health Plan, Inc.*, 999 F.2d 289 (8th Cir. 1993) 2

New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645 (1995) 2,3

Pilot Life Ins. Co. v. *Dedeaux*, 481 U.S. 41 (1987) 2,3

Statutes

Section 502(a) of ERISA, 29 U.S.C. § 1132(a) 1,2

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) 2,3

Miscellaneous

Patients' Bill of Rights Act of 1999 (S. 1344) 3

SUPPLEMENTAL BRIEF FOR PETITIONER

Pursuant to Rule 15.8 of the Rules of this Court, Petitioner wishes to call this Court's attention to two significant new decisions that were rendered subsequent to the filing of the Reply Brief for Petitioner.

On August 2, 1999, the United States Court of Appeals for the First Circuit decided *Danca* v. *Private Health Care Systems, Inc.*, ___ F.3d ___, No. 98-1754, 1999 WL 552604, a case in which the court was confronted with medical malpractice claims closely analogous to those asserted here but engaged in an ERISA preemption analysis that irreconcilably conflicts with that performed by the Pennsylvania Supreme Court in this case.

In *Danca*, just as in this case, plaintiff's physician recommended treatment at a particular hospital but the defendant HMO denied precertification for treatment at that hospital and instead precertified the plaintiff's admission to a different hospital. The plaintiff alleged that the hospital to which she was admitted was "inappropriate" and rendered inadequate care. 1999 WL 552604 at *1.

The gravamen of the plaintiff's claims in *Danca* was that the HMO had acted negligently in failing to precertify her admission to the hospital recommended by her physician. The First Circuit held that this conduct "was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan," and therefore any state law attack on this conduct would amount to an "alternative enforcement mechanism" to the civil enforcement provisions in Section 502(a) of ERISA, 29 U.S.C. § 1132(a). *Id.* at *4. As such, the court concluded that these claims "are both completely preempted [under Section 502(a)], justifying removal, and preempted by ERISA § 514, justifying dismissal." *Id.* at *5. The court acknowledged that "the practical result" of its decision was to leave the plaintiff without a remedy for the HMO's alleged negligence in refusing to precertify her admission to the hospital recommended by her physician, but it emphasized that "it is the job of Congress and not this Court to provide for such a remedy if it sees fit." *Id.* at *6 n.10.

The Eighth Circuit reached a similar decision in *Hull* v. *Fallon*, ___ F.3d ___, No. 99-1036, 1999 WL 637073 (Aug. 23, 1999), a case in which a plan subscriber sued the administrator of his health plan for medical malpractice after the plan administrator denied preauthorization for a medical test requested by the subscriber's treating physician. The Eighth Circuit held that the plaintiff's claim, even if styled as medical malpractice, was based on a denial of benefits. *Id.* at *3. As such, it fell squarely within the scope of ERISA Section 502(a) and was completely preempted.[1] *Id.* at *3. As the court explained, to hold that malpractice claims based on denial of authorization for benefits "are not preempted would be to expose plan administrators to varying state causes of action for claims within the scope of section 502(a)," in violation of this Court's decision in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987).

The *Hull* decision is also notable because, in the course of holding that ERISA Section 502(a) applied to the plaintiff's medical malpractice claim, the Eighth Circuit reaffirmed its prior decision in *Kuhl* v. *Lincoln National Health Plan, Inc.*, 999 F.2d 289 (8th Cir. 1993), which pre-dated *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). *Kuhl* is strikingly similar to this case: it involved medical malpractice and other common law claims based on a plan administrator's refusal to authorize medical treatment at a non-participating hospital as requested by the subscriber's treating physician. 999 F.2d at 300. The *Kuhl* court held that those claims were preempted under Section 514(a) of ERISA, a holding that cannot be reconciled with the decision below.

The recent *Danca* and *Hull* decisions thus deepen even further the conflict between the Pennsylvania Supreme Court and the federal appellate courts over whether Section 514(a) of ERISA preempts negligence claims against an HMO arising from the administration of claims for benefits under an ERISA plan. See Pet. 15-17. Many of the federal appellate decisions finding

---

[1] As petitioners have explained, where a claim is completely preempted under Section 502(a) of ERISA it is also preempted under Section 514(a) of ERISA. See Pet. 14 n.3; see also Pet. Reply Br. 6.

preemption, like *Danca* and *Hull*, post-date this Court's decision in *Travelers*, 514 U.S. 645, and continue to rely on this Court's holding in *Pilot Life*, 481 U.S. at 56. The First and Eighth Circuits obviously disagree with the Pennsylvania Supreme Court's view that *Pilot Life* was overruled *sub silentio* in *Travelers* and is "superannuated." Pet. App. 9a.

Moreover, the First Circuit's declaration in *Danca* that it is within the sole province of Congress to amend ERISA if it sees fit to do so stands in stark contrast to the Pennsylvania Supreme Court's judicial evisceration of the preemption afforded by ERISA Section 514(a) through its sweeping holding that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 11a. The conflict between that unprecedented construction of Section 514(a) and the intent of Congress was further manifested during the recent debate on the Patients' Bill of Rights Act of 1999, when the Senate refused to adopt proposed amendments to ERISA Section 514 that would have allowed personal injury lawsuits against HMOs. See Pet. Reply Br. 9-10.

The negligence claims in this case and *Danca* are identical inasmuch as they both arise from an HMO's precertification decision not to approve a subscriber's admission to the particular hospital desired by the subscriber's physician. The malpractice claim in *Hull* is also strikingly similar, resting on a preauthorization decision not to approve a particular treatment requested by the subscriber's physician. Nonetheless, the conflicting approaches to ERISA preemption taken by the Pennsylvania Supreme Court and First and Eighth Circuits yielded dramatically conflicting rulings. In light of the direct and recurring conflict between the Pennsylvania Supreme Court's decision and the decisions of numerous federal courts of appeals, certiorari should be granted.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

BURT M. RUBLIN
BALLARD SPAHR ANDREWS &
INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

SEPTEMBER 1999

(5)

Supreme Court, U.S.
FILED
NOV 2 - 1999
OFFICE OF THE CLERK

No. 98-1836

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE PENNSYLVANIA SUPREME COURT

SUPPLEMENTAL BRIEF FOR RESPONDENTS

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

155431

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

3

SUPPLEMENTAL BRIEF FOR RESPONDENTS

Pursuant to Rule 15.8 of the rules of your Honorable Court, respondents wish to direct your Court's attention to a new decision which was not available at the time of filing of Respondents' Brief in Opposition.

On September 16, 1999, the United States Court of Appeals for the Third Circuit decided *Bauman v. U.S. Healthcare, Inc.*, __ F.3d __, Nos. 98-5222, 98-5262, 98-5263, 1999 U.S. App. Lexis 22464. Therein, the Third Circuit affirmed the district court's decision that three counts of plaintiffs' medical malpractice complaint were not completely pre-empted by § 502(a) of ERISA, 29 U.S.C. § 1132(a)(1)(b). Furthermore, the court reversed the lower court's decision that another count (Count Six) was completely pre-empted. Count Six alleged the defendant HMO was negligent because it did not provide for an in-home visit by a pediatric nurse. The Third Circuit remanded Count Six to district court, with instructions to remand it to state court, remarking "it is that court that will be in a position to decide the express pre-emption issue". 1999 U.S. App. Lexis 22464 at *34.

In beginning its analysis, the court noted that it was "revisit[ing] the issue of 'complete pre-emption' under the Employee Retirement Income Security Act . . . last considered in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995)." *Id.* at *2. The Third Circuit regarded Count Six of the complaint as stating a claim concerning the adequacy of care, given that it was directed to the HMO as a medical provider. Repeating its reasoning in *Dukes*, the court held "Count Six sets forth an ordinary state law tort claim for medical malpractice." *Id.* at *32. The *Bauman* decision

reinforces the analysis and judgment of the Pennsylvania Supreme Court, in that ERISA does not preempt claims based upon an HMO's decision which merely seems to be a benefit determination, but the gravamen of which is really medical negligence.

The recently decided *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999) and *Danca v. Private Healthcare Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999), neither support petitioner nor conflict with the Pennsylvania Supreme Court's decision in the instant matter. In both cases, the Circuit Courts of Appeals found the plaintiffs' claims came within the scope of § 502(a), and thus were completely pre-empted. The *Hull* decision does not discuss § 514(a). The *Danca* court merely reiterates that because those claims were completely pre-empted under § 502(a), they were also pre-empted by § 514(a). 1999 U.S. App. Lexis 18043 at *16.

The issue herein is the "relate to" language of § 514, not the civil enforcement provision of § 502. There is no conflict between the Pennsylvania Supreme Court and the *Hull* and *Danca* decisions. The ruling of the Pennsylvania Supreme Court does not touch on the complete-preemption exception of those state laws which fall within the civil enforcement provision of § 502. The court correctly addressed the "relate to" language of § 514 which is at issue here.

CONCLUSION

The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

Supreme Court, U.S.
FILED
DEC 17 1999
CLERK

No. 98-1836

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC., PETITIONER

v.

PENNSYLVANIA HOSPITAL INSURANCE CO., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

SETH P. WAXMAN
Solicitor General
Counsel of Record

EDWIN S. KNEEDLER
Deputy Solicitor General

JAMES A. FELDMAN
Assistant to the Solicitor General
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

HENRY L. SOLANO
Solicitor of Labor

ALLEN H. FELDMAN
Associate Solicitor

NATHANIEL I. SPILLER
Deputy Associate Solicitor

ELLEN L. BEARD
Attorney
Department of Labor
Washington, D.C. 20210

QUESTION PRESENTED

Whether Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), preempts state law claims arising from a health maintenance organization's negligence in denying a claim for benefits under an ERISA-governed health plan.

TABLE OF CONTENTS

	Page
Statement	1
Discussion	6
Conclusion	20

TABLE OF AUTHORITIES

Cases:

Anderson v. *Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994)	8-9
Bast v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998), cert. denied, 120 S. Ct. 170 (1999)	17
Cagle v. *Bruner*, 112 F.3d 1510 (11th Cir. 1997)	13
Cannon v. *Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir.), cert. denied, 519 U.S. 816 (1996)	11, 17
Corcoran v. *United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)	11, 12, 17
Cox Broadcasting Corp. v. *Cohn*, 420 U.S. 469 (1975)	7
Danca v. *Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999)	9, 17, 18
De Buono v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997)	5, 16
Donovan v. *Dillingham*, 688 F.2d 1367 (11th Cir. 1982)	9
Dukes v. *U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir), cert. denied, 516 U.S. 1009 (1995)	5, 8, 10
Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1 (1987)	8
Grimo v. *Blue Cross/Blue Shield*, 34 F.3d 148 (2d Cir. 1994)	9
Group Life & Health Ins. Co. v. *Royal Drug Co.*, 440 U.S. 205 (1979)	8
Hull v. *Fallon*, 188 F.3d 939 (8th Cir. 1999)	17
In Home Health, Inc. v. *Prudential Ins. Co. of Am.*, 101 F.3d 600 (8th Cir. 1996)	13
Ingersoll-Rand Co. v. *McClendon*, 498 U.S. 133 (1990)	7

Cases—Continued: Page

Jass v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) 17
Kenney v. *Roland Parson Contracting Corp.*, 28 F.3d 1254 (D.C. Cir. 1994) 9
Kuhl v. *Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994) 11, 17, 18
Lordmann Enters., Inc. v. *Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995) 13
Lupo v. *Human Affairs Int'l, Inc.*, 28 F.2d 269 (2d Cir. 1994) 10
Massachusetts Mut. Life Ins. Co. v. *Russell*, 473 U.S. 134 (1985) 8
Memorial Hosp. Sys. v. *Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) 13
Mertens v. *Hewitt Assocs.*, 508 U.S. 248 (1993) 8, 12
Metropolitan Life Ins. Co. v. *Massachusetts*, 471 U.S. 724 (1985) 17
Metropolitan Life Ins. Co. v. *Taylor*, 481 U.S. 58 (1987) 18
New York State Conference of Blue Cross & Blue Sheild Plans v. *Travelers Insurance Co.*, 514 U.S. 645 (1995) 4, 5, 16
Pacificare of Okla., Inc. v. *Burrage*, 59 F.3d 151 (10th Cir. 1995) 10
Parrino v. *FHP, Inc.*, 146 F.3d 699 (9th Cir.), cert. denied, 119 S. Ct. 510 (1998) 10-11
Pilot Life Insurance Co. v. *Dedeaux*, 481 U.S. 41 (1987) 6, 14, 15, 16
Rice v. *Panchal*, 65 F.3d 637 (7th Cir. 1995) 10
Shaw v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1963) 17
Texas Pharmacy Ass'n v. *Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir.), cert. denied, 522 U.S. 820 (1997) 9

Cases—Continued: Page

Tolton v. *American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) 17
Turner v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997), cert. denied, 523 U.S. 1072 (1998) 11
UNUM Life Ins. Co. of Am. v. *Ward*, 119 S. Ct. 1380 (1999) 8, 14, 15, 16
U.S. Healthcare, Inc., In re, 193 F.3d 151 (3d Cir. 1999) 8, 10
Washington Pysicians' Serv. Ass'n v. *Gregoire*, 147 F.3d 1039 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999) 8

Statutes and regulations:

Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*:
§ 3(1), 29 U.S.C. 1002(1) 1, 9
§ 502(a), 29 U.S.C. 1132(a) 13, 14, 15
§ 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B) 12
§ 502(a)(3), 29 U.S.C. 1132(a)(3) 12
§ 514, 29 U.S.C. 1144 8
§ 514(a), 29 U.S.C. 1144(a) 14, 15
§ 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A) 14
§ 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B) 15
McCarran-Ferguson Act, 15 U.S.C. 1012 8
28 U.S.C. 1257(a) 9
29 C.F.R.:
Section 2560.503-1(c) 11
Section 2560.503-1(g)(2) 11
Section 2560.503-1(j) 11

Miscellaneous: Page

63 Fed. Reg. (1998):
p. 48,406 11
p. 48,408 11
Employee Retirement Income Security Act Preemption: Remedies for Denied or Delayed Claims: Hearing Before a Subcomm. of the Senate Comm. on Appropriations, 105th Cong., 2d Sess. (1998) 7
H.R. 2990, 106th Cong., 1st Sess. (1999) 8

In the Supreme Court of the United States

No. 98-1836

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC., PETITIONER

v.

PENNSYLVANIA HOSPITAL INSURANCE CO., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. The original plaintiffs in this case, Basile and Theodora Pappas, were subscribers to a health maintenance organization (HMO) operated by petitioner United States Healthcare Systems of Pennsylvania, Inc., a subsidiary of Aetna, Inc. Pet. App. 20a; Pet. ii. The Pappases received HMO coverage through an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(1), sponsored by Mrs. Pappas' employer, The Charming Shoppes. Pet. App. 35a-36a. Petitioner's HMO provided most medical care by con-

tracting with participating providers. Pet. 2. In a medical emergency, however, the HMO covered treatment by non-participating providers. Super. Ct. Reproduced R. ("R.") 156a ("Emergency care is covered anytime, anywhere."); *id.* at 158a ("In an emergency, you should contact your primary care physician for help. When a delay would be detrimental to your health, seek the nearest medical attention. Always call the toll-free number on the back of your membership card * * * within 24 hours after receiving emergency care.").

On May 20, 1991, Mr. Pappas went to his primary care doctor, Dr. David Asbel, complaining of neck and shoulder pain, and was treated with an injection of steroids. Pet. App. 35a. The next morning, after his condition had worsened, Pappas was transported by ambulance to Haverford Community Hospital (Haverford), where he was admitted at 11:00 a.m. By that time, he was paralyzed from the chest down. The emergency room physician, Dr. Stephen Dickter, in consultation with a neurologist and a neurosurgeon, diagnosed a probable epidural abscess pressing on Pappas' spine, a neurological emergency requiring immediate surgery. By 12:30 p.m., Dr. Dickter had made arrangements to transfer Pappas to Thomas Jefferson University Hospital (Jefferson), which had a spinal cord trauma unit able to commit to his immediate admission. *Id.* at 2a-3a, 21a, 36a.

At 12:40 p.m/, the ambulance service that was to transport Pappas to Jefferson told Dr. Dickter that petitioner would not authorize Pappas's transfer to Jefferson. At 12:50 p.m., Dr. Dickter called petitioner to request authorization, making clear that the situation was a neurological emergency. Pet. App. 3a, 21a, 36a. At 1:05, a representative of petitioner told Dr. Dickter that petitioner would not authorize treatment at Jefferson because it was not approved by petitioner, but that it would cover treatment at any of three other participating university hospitals. *Id.* at 21a, 36a. Dr.

Dickter then initiated a series of telephone calls to arrange for Pappas's admission at one of the three approved hospitals, resulting in further delays before he underwent surgery that evening. *Id.* at 3a, 21a-22a, 36a-37a. Pappas now suffers from permanent quadriplegia caused by compression of his spine by the abscess. *Id.* at 3a, 22a, 37a, 51a-52a.

2. The Pappases brought a common law tort action in state court against Dr. Asbel and Haverford, alleging that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring Pappas. Pet. App. 3a, 22a. Haverford filed a third-party complaint against petitioner, joining it as a defendant for refusing to authorize Pappas's transfer to Jefferson and adopting (for purposes of that third-party complaint) the negligence claims made against Haverford in the original complaint. *Id.* at 3a, 22a, 37a, 41a, 60a.[1]

The Pennsylvania trial court granted summary judgment to petitioner. Pet. App. 34a-44a. It held that ERISA preempts Haverford's third-party complaint because "[a]ll of [its] allegations fall within the rubric of administration of an employee benefit plan." *Id.* at 41a. Thus, it considered this case analogous to cases preempting state claims for "failure to pay a benefit claim or preapprove a procedure," which have an "obvious connection or reference to a benefit plan," and different from cases holding that "ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability generally or ostensible agency specifically" based on the negligence of others in furnishing care. *Id.* at 42a-43a.

---

[1] Dr. Asbel also filed a cross-claim against petitioner seeking contribution and indemnity, Pet. App. 3a-4a, 22a, 37a, which apparently was not pursued and is not before this Court. See Pet. 5-6; Pet. App. 22a n.2, 38a, 46a.

Plaintiffs' claims against Dr. Asbel and Haverford were later settled. Pet. App. 4a n.2, 22a n.2, 45a-46a. The trial court entered an order approving the settlement, substituting respondents Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund for Haverford as the real parties in interest, and declaring final its earlier order granting summary judgment to petitioner. *Id.* at 46a. Respondents appealed.

3. The Pennsylvania Superior Court reversed and remanded. Pet. App. 18a-33a. Characterizing the negligence claim here as "an indirect source of merely economic influence on administrative decisions," *id.* at 28a (citation omitted), it reasoned that "ERISA is in no way implicated by the claim that [petitioner] negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer." *Id.* at 31a. Despite its observation that "the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations," *id.* at 27a, the Superior Court concluded that the claims are directly related to "general health care regulation" rather than plan administration, and thus are presumptively left to the States under *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645 (1995). Pet. App. 26a-28a.[2]

---

[2] The court also noted that, "if the original complaint had claimed that [petitioner] was vicariously liable because of the negligence of its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question" that the claim would withstand preemption. Pet. App. 31a-32a. In fact, the record is unclear on whether either Dr. Asbel or Haverford had a contractual relationship with petitioner as a participating provider in its HMO network. Since the HMO is structured to provide services through primary care physicians, and Dr. Asbel, an osteopath, performed that role for Mr. Pappas, we assume that he was a participating provider. See Pet. App. 3a, 20a; R. 158a. Dr. Dickter, who had worked full-time in Haverford's emergency room for ten months at

4. The Pennsylvania Supreme Court affirmed. Pet. App. 1a-13a. The court held broadly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." *Id.* at 11a. It reached that conclusion based on the view that this Court "noticeably changed tack" in its *Travelers* decision, *id.* at 7a, interpreting ERISA's pre-emption provision less expansively than in earlier cases. *Id.* at 9a. *Travelers*, the court said, established that "Congress did not intend to preempt state laws which govern the provision of safe medical care." *Id.* at 11a. Since "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care," the court concluded that the claims in this case are not preempted. *Id.* at 11a-12a. The court also reasoned that state negligence laws of general applicability have only a "tenuous, remote, or peripheral connection with [ERISA] covered plans," and have only an incidental impact on the fees charged by HMOs to ERISA plans. *Id.* at 12a (citing *Travelers*, 514 U.S. at 661, and *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-816 (1997)).[3]

Justice Nigro concurred separately. Pet. App. 14a-16a. In his view, ERISA does not preempt the third-party claims because petitioner's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Id.* at 15a. Relying on *Dukes* v. *U.S. Healthcare, Inc.*, 57

---

the time of these events, testified that he had never previously called petitioner for any purpose. R. 60a, 67a. This suggests, if anything, that Haverford was not a participating provider.

[3] The court disagreed, however, with the Superior Court's reasoning that the state-law claims at issue here are not preempted because "Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs." Pet. App. 12a n.6.

F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995), he concluded that this case involves claims about the quality of health care benefits actually received, which are not preempted by ERISA, rather than claims that the quantum of benefits promised was not provided, a dispute that ERISA does control. Pet. App. 15a-16a.

DISCUSSION

The Pennsylvania Supreme Court held flatly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 11a. In our view, that holding is both overbroad and incorrect as applied to this case. In many circumstances, including this case, the blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41, 48 (1987), that ERISA preempts state common-law causes of action for improper processing of a claim for benefits under an employee benefit plan. The Pennsylvania Supreme Court's decision also conflicts with a number of federal court of appeals decisions holding that ERISA preempts state-law claims challenging decisions by HMOs and other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals. Finally, questions regarding the scope of ERISA preemption of negligence claims against HMOs are currently of great nationwide importance. This Court's disposition of *Pegram* v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000), may have relevance to this case, and we therefore suggest that the Court hold the petition in this case pending its decision in *Pegram*. But both the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here, suggest that, if

Pegram does not clearly resolve this case, plenary review would be warranted.[4]

1. Based on the limited but undisputed facts of record in this case, it appears that petitioner denied Mr. Pappas a benefit he was entitled to receive under the terms of his plan —emergency care at a hospital outside the HMO network— and that respondents seek to hold petitioner liable for its negligence in making that erroneous benefit determination. When viewed in that light, respondents' claims are preempted by ERISA because they relate to plan administration and would provide an independent enforcement mechanism as an alternative to ERISA's limited remedies. As a result, the Pennsylvania Supreme Court decision is both incorrect in this case and overbroad as a general matter under existing law.[5]

---

[4] Respondents argue (Br. in Opp. 4-5) that this Court lacks jurisdiction under 28 U.S.C. 1257(a) because the decision of the Pennsylvania Supreme Court is not a final judgment. We agree with petitioner (Reply Br. 1-6) that this case meets the four requirements for immediate review under *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469, 482-483 (1975): (1) the federal question, concerning ERISA preemption, has been finally decided; (2) petitioner might prevail on remand on nonfederal grounds, making review of the federal issue unnecessary; (3) reversal of the state court judgment on preemption grounds would preclude further litigation; and (4) denying immediate review might seriously erode federal policy regarding the scope of ERISA preemption of tort claims against HMOs. This Court has previously granted certiorari to review an ERISA preemption case in a similar posture without commenting on any jurisdictional issue. See *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 136-137 (1990) (reviewing case in which Texas Supreme Court, holding that state wrongful discharge claims were not preempted, had reversed and remanded for trial).

[5] The Department of Labor has supported proposed amendments to ERISA to provide more effective remedies for improper benefit determinations, either by narrowing ERISA preemption or strengthening ERISA remedies or both. See *ERISA Preemption: Remedies for Denied or Delayed Claims: Hearing Before a Subcomm. of the Senate Comm. on Appropriations*, 105th Cong., 2d Sess. 5-14 (1998) (testimony of Assistant

As we explain in our recent amicus brief in *Pegram* v. *Herdrich*, No. 98-1949 (filed November 19, 1999), an HMO can perform various functions in relation to an employee welfare benefit plan. *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162 (3d Cir. 1999); *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir.), cert. denied, 516 U.S. 1009 (1995). First, by its very nature, an HMO serves as a medical-service provider to the plan, contracting for or directly providing medical care to the plan's participants and beneficiaries. *In re U.S. Healthcare*, 193 F.3d at 162. Second, it may serve as a plan administrator, performing administrative duties such as determining eligibility for benefits, calculating and disbursing benefits, monitoring available funds, and keeping records. *Ibid.*; see also *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987).[6] Those roles can and should be distinguished

---

Secretary Olena Berg) [hereinafter Berg Testimony]; see also H.R. 2990, 106th Cong., 1st Sess. § 1302 (1999) (provision in House-passed version of Patients' Bill of Rights amending Section 514 of ERISA, 29 U.S.C. 1144, to save from preemption certain state personal injury claims involving group health plans). The Department's position is based on the belief that participants and beneficiaries of ERISA-covered health plans currently have inadequate remedies for the negligence of plan administrators in making benefit determinations. ERISA itself does not provide compensatory damages for the improper processing of benefit claims. *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248 (1993); *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134 (1985). At the same time, under *Pilot Life*, ERISA appears to preempt most, if not all, state-law causes of action that could provide such relief. Cf. *UNUM Life Ins. Co. of Am.* v. *Ward*, 119 S. Ct. 1380, 1390-1391 n.7 (1999).

[6] An HMO also acts as an insurer to the extent that it bears risk. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) (noting that "certain aspects" of advance-payment medical-benefits plans may be the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012). See also *Washington Physicians' Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045-1046 (9th Cir. 1998) (an HMO "provides medical services directly" and also is "in the business of insurance"), cert. denied, 119 S. Ct. 1033 (1999); *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th

for purposes of ERISA preemption analysis, but the Pennsylvania Supreme Court failed to do so.

To understand those roles, it is helpful to begin with ERISA's definition of a plan—particularly since both Pennsylvania appellate courts incorrectly assumed that petitioner's HMO is identical to the employee benefit plan sponsored by Mrs. Pappas's employer. Pet. App. 4a n.1, 23a n.3. ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program * * * established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise * * * medical, surgical, or hospital care or benefits" or other benefits. 29 U.S.C. 1002(1). Based on that definition, the essentials of a plan have been interpreted to be the existence of "intended benefits, a class of beneficiaries, [a] source of financing, and procedures for receiving benefits." *Donovan* v. *Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982); accord *Grimo* v. *Blue Cross/Blue Shield*, 34 F.3d 148, 151 (2d Cir. 1994); *Kenney* v. *Roland Parson Contracting Corp.*, 28 F.3d 1254, 1257-1258 (D.C. Cir. 1994) (collecting cases).

The ERISA plan in this case was the arrangement by which The Charming Shoppes, Mrs. Pappas' employer, undertook to provide medical benefits to eligible employees and their families, in this instance by purchasing memberships in petitioner's HMO. The intended benefit was coverage for the specific kinds of medical care specified in the Group Master Contract between petitioner and The Charming Shoppes, care that is generally provided (except in emergencies) by doctors and hospitals under contract with petitioner. R. 158a; see *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 6 n.6 (1st Cir. 1999) (explaining that the benefits under an ERISA health plan are "the monetary payments

---

Cir. 1994). But see *Texas Pharmacy Ass'n* v. *Prudential Ins. Co.*, 105 F.3d 1035, 1038-1039 (5th Cir.), cert. denied, 522 U.S. 820 (1997).

for medical services, not the services themselves"). The intended beneficiaries were The Charming Shoppes' employees and their dependents enrolled in the HMO. The source of funding was The Charming Shoppes, which paid premiums to petitioner. Pet. 2; Pet. App. 35a-36a. And the procedure to apply for and collect benefits under the HMO is outlined in the Member Handbook and Group Master Contract. Under that procedure, petitioner decides whether to authorize or reimburse treatment. R. 158a; Pet. 17. Petitioner itself, however, is not an ERISA plan; rather, it is a service provider to the plan and to its participants and beneficiaries.

As was true here, HMOs can perform at least two different roles in their relationship with members who are enrolled under ERISA plans, and the correct identification of the role being performed can have profound consequences under ERISA. When an HMO acts as a medical service provider, a number of courts have held—and we agree—that the HMO is subject to suit under state law for negligence in performing its medical duties. *In re U.S. Healthcare, supra*; *Rice* v. *Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Okla., Inc.* v. *Burrage*, 59 F.3d 151 (10th Cir. 1995); *Dukes* v. *U.S. HealthCare, Inc.*, 57 F.3d 350 (3d Cir.), cert. denied, 516 U.S. 1009 (1995); *Lupo* v. *Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994). In those cases, the nonpreempted claims were generally either vicarious liability claims against an HMO for medical malpractice by its agents, or direct claims against the HMO for its negligence in selection and supervision of those agents. See, *e.g.*, *Dukes*, 57 F.3d at 352-353.

On the other hand, when an HMO makes benefit determinations in its role as a plan administrator, most courts have held—and we agree—that ERISA preempts any state-law challenges to those decisions. See, *e.g.*, *Parrino* v. *FHP, Inc.*, 146 F.3d 699 (9th Cir.) (HMO denial of particular cancer

treatment), cert. denied, 119 S. Ct. 510 (1998); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196 (1st Cir. 1997) (same), cert. denied, 523 U.S. 1072 (1998); *Cannon* v. *Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir.) (HMO delay in authorizing particular cancer treatment), cert. denied, 519 U.S. 816 (1996); *Kuhl* v. *Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993) (HMO delay in authorizing surgery at non-network hospital), cert. denied, 510 U.S. 1045 (1994).

The Labor Department's ERISA claims regulations (both current and proposed) also recognize that HMOs, like insurance companies and other organizations outside the plan itself, may be responsible for making claim determinations under an employee benefit plan. See 29 C.F.R. 2560.503-1(c), (g)(2) and (j); see also 63 Fed. Reg. 48,408 (1998) (proposed amended claims regulation defining an "adverse benefit determination" to include benefit denials "resulting from the application of any utilization review directed at cost containment"); see also *id.* at 48,406 (addressing claims procedures of plans in which benefits are provided by an HMO or similar entity). As both the case law and the regulations show, such benefit determinations will often involve a significant component of medical judgment, and may have tragic medical consequences. But, so long as the judgment is an adjunct to a plan coverage decision, rather than a judgment made primarily in the course of diagnosis or treatment, it is a "benefit determination nonetheless." *Corcoran* v. *United HealthCare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).[7] And benefit determinations can be chal-

---

[7] If, however, the HMO makes the treating physician's medical judgment in rendering treatment decisions the sole basis for coverage determinations under an ERISA plan, ERISA would not preempt state malpractice claims against the treating physician or state vicarious liability claims against the HMO for those treatment decisions (as opposed to the benefit decisions).

lenged only under ERISA, not under state law, as this Court held in *Pilot Life* (discussed at pp. 14-16, *infra*).

The distinction between plan administration and medical treatment may not always be easy to apply in practice. In this case, however, the Pennsylvania Supreme Court did not suggest that petitioner acted other than in its role as plan administrator, or, indeed, that petitioner exercised any medical judgment at all. Rather, the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, made a benefit determination. Although that determination conflicted with the terms of the plan regarding emergency care and may have contributed to an avoidable personal tragedy for Mr. Pappas and his wife, t was a "benefit determination nonetheless." *Corcoran*, 965 F.2d at 1332. In these circumstances, it is clear that any state-law action the Pappases themselves could have brought against petitioner for negligent claims processing or misinterpretation of plan terms would have been preempted.[8] It is equally clear that the Pappases could have (and did) bring a state negligence action against Dr. Asbel and Haverford that is entirely outside ERISA's preemptive reach.

The preemption analysis is somewhat complicated because the claim before the Court was brought by Haverford, a

---

[8] ERISA provides a participant or beneficiary with causes of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan," 29 U.S.C. 1132(a)(1)(B), and "to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or * * * to obtain other appropriate equitable relief," 29 U.S.C. 1132(a)(3). By the time the Pappases could bring suit here, however, there was no further plan benefit due to them (appropriate treatment, albeit critically delayed, had been provided and paid for), and there was no injunctive or other equitable relief that could provide an appropriate or meaningful remedy. Cf. *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 255-258 (1993) (only traditional equitable relief available under ERISA).

medical service provider, rather than directly by the Pappases. Normally, a medical service provider has standing to bring an ERISA claim only if it is an assignee of a participant or beneficiary. See 29 U.S.C. 1132(a); *Cagle* v. *Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997) (collecting cases). When a service provider brings such a derivative claim, it is limited to ERISA remedies, and ERISA preempts any remedies under state law. See, *e.g.*, *Memorial Hosp. Sys.* v. *Northbrook Life Ins. Co.*, 904 F.2d 236, 250 (5th Cir. 1990). On the other hand, a number of courts have held that a service provider can sometimes bring an independent state-law action against a plan administrator for negligent misrepresentation without running afoul of ERISA preemption. *In Home Health, Inc.* v. *Prudential Ins. Co. of Am.*, 101 F.3d 600, 604 (8th Cir. 1996) (collecting cases). In those cases, a service provider has typically contacted a plan administrator to ask whether an individual is covered by the plan, been assured that coverage existed, provided services in reliance on that assurance, and later been refused payment on the ground that coverage did not exist under the plan. See, *e.g.*, *id.* at 602; *Lordmann Enters., Inc.* v. *Equicor, Inc.*, 32 F.3d 1529, 1530-1531 (11th Cir. 1994), cert. denied, 516 U.S. 930 (1995); *Memorial Hosp. Sys.*, 904 F.2d at 238.

Although neither line of service-provider cases addresses the precise scenario presented here, their underlying principles support the conclusion that respondents' claims are preempted. Haverford's third-party complaint alleged that petitioner was liable for Haverford's delay in transferring Mr. Pappas to a suitable hospital. Pet. App. 60a. It did not allege that petitioner misled it or reneged on any promise. The only specific allegation against petitioner is that petitioner refused to authorize coverage of treatment at Jefferson, when asked to do so by Haverford on behalf of Mr. Pappas. Under these circumstances, the complaint necessarily alleges that petitioner made a benefit determination un-

der the plan, which can be challenged only under ERISA. Respondents' common-law negligence claim is therefore preempted.[9]

2. In *Pilot Life*, the Court held that ERISA preempts state common law causes of action "based on alleged improper processing of a claim for benefits under an employee benefit plan." 481 U.S. at 48. It reached that conclusion for three reasons: (1) there was "no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan" within the meaning of ERISA's express preemption provision, Section 514(a), 29 U.S.C. 1144(a), 481 U.S. at 47; (2) the state- law claims were not saved from preemption by the insurance savings clause in Section 514(b)(2)(A) of ERISA, 29 U.S.C. 1144(b)(2)(A), 481 U.S. at 48-51; and (3) the civil enforcement provisions of Section 502(a) of ERISA, 29 U.S.C. 1132(a), are "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." 481 U.S. at 52. The Pennsylvania Supreme Court's decision in this case conflicts with the first and third rationales for the *Pilot Life* holding.[10]

---

[9] It is possible that other state-law causes of action could have been alleged in this case that would not be preempted. For example, if Dr. Asbel was a network provider, the Pappases could have alleged that petitioner was vicariously liable for his malpractice or directly negligent in selecting him as a provider. See cases cited at page 10, *supra*. But no such claims were made.

[10] The second rationale for the *Pilot Life* holding is not at issue in this case. As previously noted, p. 8 n.6, *supra*, the Secretary has argued, and several courts have held, that HMOs can be insurers for purposes of the insurance savings clause to the extent they bear insurance risks. There is no contention, however, that respondents' claims against petitioner are based on a state insurance law. Rather, like the claim in *Pilot Life*, they are based on generally applicable tort law. Thus, unlike *UNUM Life Insurance Co. of America* v. *Ward*, 119 S. Ct. 1380, 1390-1391 n.7 (1999), this case does not involve ERISA's insurance savings clause or its construction

Pilot Life involved a claim for long-term disability benefits under an ERISA plan administered by an insurance company, which bore the responsibility for making benefit determinations; the plaintiff was a plan participant whose benefits the insurer had terminated and reinstated several times. 481 U.S. at 43. The Court, however, did not focus on either the type of benefits or the reasons for their termination and reinstatement. Applying *Pilot Life* in this case, the benefit at issue was coverage or payment for emergency medical treatment at a hospital outside the HMO network of participating providers. Coverage was denied before treatment was provided, rather than after, even though preauthorization was not required in an emergency, and the denial was for reasons that contradicted the plain language of petitioner's own brochure describing the covered benefits. Nevertheless, as discussed at pages 12-13, *supra*, the cause of action here, like the one in *Pilot Life*, in essence is "based on alleged improper processing of a claim for benefits under an employee benefit plan," which this Court held is expressly preempted by Section 514(a) of ERISA. 481 U.S. at 48.

Pilot Life also relied on a theory of field preemption, holding that "Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." 481 U.S. at 52. While this Court has never delineated the boundaries of that preempted field in the context of health care benefits, it seems clear that they overlap with the boundaries of the field that the Pennsylvania court declared nonpreempted—that is, all negligence claims against HMOs. In addition, we

---

in *Pilot Life*. Nor does this case involve ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B).

believe that *Pilot Life* field preemption applies to this case because respondents' claims—unlike some service-provider claims against plans—essentially challenge petitioner's denial of benefits under the plan.[11]

The Pennsylvania Supreme Court disregarded *Pilot Life* because it believed that this Court had limited that precedent's expansive interpretation of the "relate[s] to" clause in subsequent decisions such as *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995), and *De Buono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). Pet. App. 6a-13a. But while *Travelers* and *De Buono* both involved state-imposed economic burdens on the provision of health care and emphasized that health care regulation is traditionally left to the States, they did not involve state causes of action for benefits against ERISA plans. As a result, neither case can reasonably be read to limit *Pilot Life*'s holding that such causes of action "relate to" plans or that "ERISA's civil enforcement remedies were intended to be exclusive" with respect to such causes of action. 481 U.S. at 54. On the contrary, *Travelers* reaffirms the Court's earlier holdings that ERISA preempts "state laws that mandate[] employee benefit structures or their administration," as well as "state laws providing alternative enforcement mechanisms" to those contained in ERISA. 514 U.S. at 658.[12]

---

[11] We note that the Court indicated in *Pilot Life* that the field preemption effect of Section 502 extended so far as to preempt even state insurance laws that would otherwise be saved by ERISA's insurance savings clause. See 481 U.S. at 52-57. We have argued that that conclusion may be subject to doubt. See U.S. Amicus Br. 20-25, *UNUM Life Ins. Co. of Am.* v. *Ward*, 119 S. Ct. 1380 (1999). See also *UNUM*, 119 S. Ct. at 1390 n.7. That issue is not presented here, however, since the state-law cause of action at issue here is not one arising under a law that would be saved by ERISA's insurance savings clause. See note 10, *supra*.

[12] Because we do not understand the Pennsylvania Supreme Court to have "impose[d] a substantive coverage requirement on ERISA-governed

3. The Pennsylvania Supreme Court's decision also conflicts with a long list of federal court of appeals decisions, both before and after *Travelers*, holding that ERISA preempts state-law challenges to decisions by HMOs, insurers, utilization review organizations, and other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals. See, *e.g.*, *Hull* v. *Fallon*, 188 F.3d 939 (8th Cir. 1999) (refusal to authorize particular diagnostic test); *Danca* v. *Private Health Care Sys., Inc.*, *supra* (refusal to authorize treatment at a particular hospital); *Bast* v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998) (delay in authorizing particular cancer treatment), cert. denied, 120 S. Ct. 170 (1999); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) (refusal to authorize physical therapy after knee surgery); *Cannon* v. *Group Health Serv. of Okla., Inc.*, *supra* (delay in authorizing particular cancer treatment); *Tolton* v. *American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995) (refusal to authorize psychiatric benefits); *Kuhl* v. *Lincoln Nat'l Health Plan of Kansas City, Inc.*, *supra* (delay in authorizing surgery at non-network hospital); *Corcoran* v. *United HealthCare, Inc.*, *supra* (refusal to authorize hospitalization during high-risk pregnancy). Two of those cases, *Danca* and *Kuhl*, specifically involved decisions by a utilization review or health maintenance organization to deny preauthorization for treatment at a particular hospital recommended by the patient's treating physician.

In each of those cases from seven different circuits, the courts treated a decision to deny pre-authorization for medical treatment as a type of benefit determination for which a

---

health plans," Pet. 8, as distinct from having subjected petitioner to suit for an erroneous or negligently delayed coverage determination, we do not agree with petitioner that the decision below conflicts with *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), or *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983). See Pet. 8-9.

state-law claim is preempted under *Pilot Life*, and also often completely preempted under *Metropolitian Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), requiring removal to federal court. See, *e.g.*, *Danca*, 185 F.3d at 5-6; *Kuhl*, 999 F.2d at 302-303. Thus, the federal courts of appeals have concluded uniformly that *Pilot Life* mandates preemption of state-law negligence claims alleging improper benefit determinations by managed health care organizations acting on behalf of ERISA plans. The decision of the Pennsylvania Supreme Court is in conflict with those decisions.

4. We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided. See Berg Testimony at 14. The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.

5. In *Pegram* v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000), this Court granted certiorari to review a Seventh Circuit decision holding that individuals who obtained membership in an HMO through an ERISA plan stated a claim of breach of fiduciary duty, in violation of ERISA. The plaintiff's allegations in *Pegram* concern the HMO's allegedly improper incentive payments to HMO physicians in connection with two kinds of conduct—the minimization of certain costly forms of treatment and the physicians' determination of whether certain claims fall within the scope of the medical benefits provided by the HMO.

There is a connection between the second set of allegations—the "administration" or claims-processing allegations —in *Pegram* and the allegations in this case. For example, one of the arguments advanced by the petitioners in *Pegram* (Pet. Br. 24-26)—an argument with which we disagree (see U.S. Br. 24-26)—is that the "intended benefit" in an ERISA plan that provides medical benefits through an HMO is simply membership in the HMO, not the particular medical benefits to be provided by the HMO. If, however, that contention were correct, then the conduct of the HMO in this case would not involve a claim for benefits under an ERISA plan (because it would not involve a question of membership in the HMO), and it is likely that the state-law negligence claim would therefore not be preempted (though for a reason different than that given by the Pennsylvania Supreme Court). Even if the Court rejects petitioners' contention in *Pegram* (as we believe it should), the decision in *Pegram* still could affect this case. We argue in *Pegram* (at Br. 20-23), as we argue above, see pp. 11-12, that the "administration" claims in *Pegram* are controlled by the principle that determinations regarding the benefits due under ERISA plans are governed by ERISA and its fiduciary duty standards, and we rely on this Court's precedents holding that state-law claims based on the performance of such duties are preempted precisely because they *are* governed by ERISA. If the Court adopts that view in *Pegram* and reaffirms the underlying principle, it would effectively hold or at least strongly imply that claims (such as the "administration" claims in *Pegram* and the claim in this case) regarding allegedly improper benefits determinations under ERISA plans are not subject to state law.

In short, the Court's disposition of *Pegram* could significantly illuminate the question presented in this case. For that reason, the Court may wish to hold the petition in this case pending its decision in *Pegram*. Nonetheless, the ques-

tion presented in this case (concerning preemption of state-law causes of action) is fundamentally different from the question presented in *Pegram* (concerning the scope of fiduciary duties under ERISA). For the reasons given above, the question presented here is an important one, the decision below conflicts with decisions of a number of federal courts, and the issues in this case are regularly subject to litigation around the country. Accordingly, if the decision in *Pegram* does not fully dispose of the question presented in this case, the Court should grant plenary review in this case to ensure uniform interpretation of the extent to which ERISA beneficiaries may bring state-law negligence claims against HMOs.

CONCLUSION

The petition for a writ of certiorari should be held pending this Court's decision in *Pegram* v. *Herdrich*, No. 98-1949, and then disposed of accordingly. Alternatively, the petition for a writ of certiorari should be granted.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
EDWIN S. KNEEDLER
Deputy Solicitor General
JAMES A. FELDMAN
Assistant to the Solicitor General

HENRY L. SOLANO
Solicitor of Labor
ALLEN H. FELDMAN
Associate Solicitor
NATHANIEL I. SPILLER
Deputy Associate Solicitor
ELLEN L. BEARD
Attorney
Department of Labor

DECEMBER 1999

(7)

No. 98-1836

Supreme Court, U.S.
FILED
DEC 23 1999

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

7PP

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

CONCLUSION 4

TABLE OF AUTHORITIES

Page(s)

Cases

Herdrich v. *Pegram*, 170 F.3d 683 (7th Cir. 1999) 3

Pegram v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000) . . . . . *passim*

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

Pursuant to Rule 15.8 of the Rules of this Court, petitioner submits this brief in response to the Brief for the United States as Amicus Curiae, filed December 17, 1999. Petitioner welcomes, and therefore will not respond to, the vast majority of the government's analysis.[1] In one important respect, however, petitioner disagrees with the government: the Court should grant the petition for a writ of certiorari outright, not hold this case pending its disposition of *Pegram* v. *Herdrich*, No. 98-1949 (to be argued Feb. 23, 2000).

This case presents an issue of ERISA preemption of a state-law negligence action against a health maintenance organization (HMO). *Pegram* presents an issue of fiduciary liability under ERISA for an HMO. As the government acknowledges (at 23), these issues are "fundamentally different."

The former subject has prompted huge amounts of litigation throughout the federal and state court systems, as is evident from the government's amicus brief in this case as well as petitioner's own submissions. See, *e.g.*, U.S. Br. 19-21 (collecting cases). "The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise." *Id.* at 21. Fiduciary liability under ERISA for HMOs' administrative and medical decisions, by contrast, has been a

---

[1] Although certain points of disagreement between the government and petitioner remain (*e.g.*, the government's assertion at 19 n.12 that the decision below is in conflict with only one prior decision of this Court, rather than three), those disagreements do not affect either the correct resolution of the case on the merits or its certworthiness, and therefore do not warrant further discussion at this stage.

subject of relatively infrequent litigation. The disparity is not surprising, given the incentives plaintiffs' counsel have to seek much larger recoveries under state tort law than are typically available under ERISA's remedial provisions.

The government contends (at 22) that "there is a connection between [some of the] allegations * * * in *Pegram* and the allegations in this case," and that there is a significant chance that this Court will effectively resolve the preemption issue in this case in the course of its reasoning concerning the fiduciary-duty issue in *Pegram*. If so, that is ***more*** reason, not less, why the Court should order full briefing and argument in this case. As the government acknowledges, and as the volume of litigation shows, the preemption issue is immensely important in practical terms. One need not gainsay the importance in its own right of the fiduciary-duty issue in order to recognize that the preemption issue should be decided in a case involving full briefing and argument on the merits of ***that*** issue, not incidentally in a case involving a different issue. Any possible bearing the preemption issue has on the Court's disposition of *Pegram* calls for a more careful consideration of the preemption issue in a case in which it is actually raised, rather than a disposition of *Pegram* while the present case is merely held. The Court can make a better informed judgment in ***both*** *Pegram* and this case if it has received full briefing and heard oral argument in both cases before rendering decision in either.[2]

---

[2] Although *Pegram* is scheduled for argument in late February and the present case could not practicably be argued until April, the Court in the ordinary course of business would still likely have *Pegram* under submission at the time it heard argument in this case. Furthermore, of course, the Court controls its own docket and could choose to await the argument of this case, if doing so was appropriate in the Court's eyes, before rendering any decision in *Pegram*.

A threshold issue being raised in *Pegram*, and highlighted in the government's brief in this case, demonstrates the need for especially careful and informed decisionmaking in both cases. The *Pegram* petitioners (who include an HMO) are arguing that the "intended benefit" in an ERISA plan that provides medical benefits through an HMO is simply membership in the HMO, not the particular medical benefits to be provided by the HMO.[3] That argument, if accepted, would cause the *Pegram* petitioners to prevail in that case but, according to the government (at 22), would "likely" defeat preemption of the state-law claims in the present case and, presumably, in virtually all actions against HMOs. In light of the potential that such a ruling could have consequences far broader than may have been intended, the Court's institutional interests will be best served if it is fully informed of both the pros and the cons of adopting such a rationale. A grant of certiorari in this case, rather than a decision to hold it for *Pegram*, will best assure informative briefing.

A final reason why this case should not be held pertains to the uncertainty it engenders in the lower courts. As long as the Pennsylvania Supreme Court's erroneous opinion remains on the books, plaintiffs' counsel will give serious consideration to bringing state-law negligence claims against HMOs, even in circumstances in which the uniform body of federal law (see U.S. Br. 21) suggests that those claims would be preempted. Such litigation may result in a massive waste of resources, as plaintiffs cling to the gossamer hope that the views of the Pennsylvania Supreme Court will ultimately prevail before this Court and become the law of the land, and as HMOs defend actions that should not be brought against them in the first place (and litigate extensively over such collateral issues as removal of cases from state to federal

---

[3] Judge Easterbrook advanced that argument in dissenting from denial of rehearing en banc in *Pegram*. *Herdrich* v. *Pegram*, 170 F.3d 683, 686 (7th Cir. 1999).

court under the "complete preemption" doctrine). That specter calls for the Pennsylvania Supreme Court's decision to be reviewed sooner rather than later. Under the government's proposed disposition of this petition, however, the Court might very well decide *Pegram*, conclude that it does not "fully dispose of the question presented in this case" (U.S. Br. 23), grant certiorari in this case, and then hear argument sometime next Term, with a decision unlikely before the year 2001. It would be unfortunate to allow the erroneous decision below to engender confusion and wasteful litigation for that entire time.

CONCLUSION

For the reasons stated by the government as well as those previously stated in the petition, reply brief, and supplemental brief, the petition for a writ of certiorari should be granted. For the reasons stated above, the grant of certiorari should not await this Court's disposition of *Pegram* v. *Herdrich*, No. 98-1949.

Respectfully submitted,

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

DECEMBER 1999

Supreme Court, U.S.
FILED
JAN 31 2000
CLERK

No. 98-1836

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE PENNSYLVANIA SUPREME COURT

SUPPLEMENTAL BRIEF FOR RESPONDENTS IN RESPONSE TO BRIEF FOR THE UNITED STATES AS *AMICUS CURIAE* AND SUPPLEMENTAL BRIEF OF PETITIONER

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

157617

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

TABLE OF CONTENTS

Page

Table of Cited Authorities ii

Supplemental Brief For Respondents In Response To Brief For The United States As *Amicus Curiae* And Supplemental Brief Of Petitioner 1

Conclusion 10

TABLE OF CITED AUTHORITIES

Page

Cases:

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997) 1, 2, 4, 6

Hinterlong v. Baldwin, 720 N.E.2d 315 (1999) ... 8

Mackey v. Lanier Collections Agency and Service, 486 U.S. 825 (1988) 2

Maryland v. Baltimore Radio Show, Inc., 338 U.S. 912 (1950) 8

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 1, 2

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) 1, 2, 4, 5, 6

Pegram v. Hendrich, 1999 U.S. Briefs 1949 (November 19, 1999) 9, 10

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 1, 2, 3, 4, 7, 9

Statute:

29 U.S.C. § 1132(a) 7

The *amicus curiae* brief submitted by the United States and the supplemental brief submitted by petitioner in response to that brief should not persuade your Honorable Court to grant the petition for writ of certiorari in this case. Instead, your Court should deny the petition, or revisit it through new briefs from the parties and the government after the Court has rendered its decision in *Pegram v. Hendrich*, No. 98-1949 (to be argued 2/23/00).

Even a casual reading of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) instantly reveals that the Pennsylvania Supreme Court correctly perceived a fundamental change in the analytical course that your Court charted to determine the validity of a claim to preemption under ERISA.

The *Metropolitan Life/Pilot Life* approach emphasized the general nature of the preemption clause's "relates to" phrase and the structure of the preemption and exception clauses: if the matter has some impact on an ERISA plan, then it may be preempted, unless it falls within the scope of the insurance exception to preemption. Thus, under the approach delineated in *Metropolitan Life/Pilot Life*, conduct that does or might affect an ERISA plan is presumptively preempted unless it falls within the scope of the exceptions to ERISA's broad preemption provision. *Metropolitan Life, supra*, 471 U.S. at 739; *Pilot Life, supra*, 481 U.S. at 47-48.

In contrast, the approach delineated in *Travelers* and *DeBuono*, began with the recognition that emphasis on the "relate to" phrase can produce a sweep of federal preemption far beyond the scope intended by Congress when it enacted ERISA, because virtually everything can be connected to an ERISA plan. *Travelers, supra*, 514 U.S. at 655; *DeBuono, supra*, 520 U.S. at 813. The *Travelers/DeBuono* analysis also recognizes that the operative and beginning presumption is against preemption, and it places on the party claiming

preemption "the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law'," *DeBuono*, 520 U.S. at 814, quoting *Travelers*, 514 U.S. at 654. Under the approach implemented in *Travelers* and followed in *DeBuono*, since preemption claims turn on Congress's intent, "we begin as we do in any exercise of statutory construction with the text of the provision in question, and move on, as need be, to the structure and purpose of the Act in which it occurs," *Travelers*, 514 U.S. at 655.

Your Honorable Court, of course, had no occasion to overrule *Metropolitan Life* and *Pilot Life* when it decided *Travelers* and *De Buono*. *Metropolitan Life* presented state action that squarely affected the substantive provisions of an ERISA plan. *Pilot Life* presented a state action that squarely conflicted with ERISA's contractual enforcement provisions. Because the state actions in those cases clearly "related to" ERISA plans and plainly conflicted with federal provisions, the Court had no reason to consider the implications of the "insofar as" limitation that Congress engrafted onto the "related to" preemption clause. *See DeBuono, supra*, 520 U.S. at 813.

This case presents a tort claim against an HMO.[1] The claim, which has not fully developed its record and on whose ultimate merits the Pennsylvania Supreme Court expressly withheld judgment, posits that the HMO contributed to the injury sustained by Mr. Pappas by referring Mr. Pappas to be treated at one of the HMO's participating hospitals without determining that those hospitals were prepared to treat him with the dispatch that his emergent medical condition demanded, at a time when another facility, not associated with the HMO, was capable of providing appropriate and timely care.[2] In essence, the case

1. In *Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988), your Honorable Court suggested that commonplace tort claims were not displaced by ERISA. (Respondents do not suggest that petitioner is an ERISA plan).

2. Although the record facts are "limited", Brief for the United States as Amicus Curiae ("U.S. brief"), p. 7, they suggest that the (Cont'd)

involves a treatment decision by the HMO to be adjudged on the basis of the standards applicable to all medical care providers in Pennsylvania, not just HMOs.

Of course, in order to draw this case under the penumbra of *Pilot Life*, the government's brief and the petitioner's filings put the proverbial rabbit into the hat by equating the conduct of the HMO in this case with the conduct of an ERISA plan administrator in making a benefits determination.

Contrary to the narrow view espoused by petitioner and endorsed by the government, the case does not simply involve a challenge to a benefits determination. Indeed, as the government's brief correctly observes, with no contradiction from petitioner, there is no question that the HMO's provisions entitled Mr. Pappas to be treated at any hospital, not just at the hospitals preferred by the HMO. Additionally, the standard by which the conduct of the HMO is ultimately and yet to be adjudged is not based on the terms of the employer's benefit plan nor on the provisions of the HMO's documents, provisions that are not restricted to any particular ERISA plan, but on the standard of care to be followed by all health care providers in the Commonwealth of Pennsylvania. Furthermore, the remedy sought in this case is not the payment of an allegedly

---

(Cont'd)
ultimate decision by the HMO was a medical determination, either that Mr. Pappas' condition was not a true emergency or that there was no need to have him treated at a hospital that was not affiliated with the HMO. Dr. Dickter, the Haverford emergency room physician who personally attempted to persuade the HMO to change its veto against transporting Mr. Pappas to a non-affiliated hospital that he had ascertained was ready to accept and treat Mr. Pappas, testified that he emphasized to the HMO representatives that the situation confronting Mr. Pappas was a neurological emergency, and that his pleas for the HMO to reevaluate and change its decision were reviewed and disapproved by the HMO's Dr. Liebowitz. *See* Pennsylvania Supreme Court Reproduced Record, p. 70a-72a, 77a (deposition testimony of Dr. Dickter), and p. 93a (typewritten transcript of emergency room chart).

contractually owed payment, but damages for personal injury in the form of contribution by an alleged joint tortfeasor.

Moreover, the equation that petitioner and the government assume between the HMO in this case and an ERISA plan or an ERISA plan administrator, in order to squeeze this case under the holding of *Pilot Life*, does not withstand close scrutiny. In *Pilot Life*, as recognized by the government's brief, the insurance company was the administrator of the ERISA plan. Similarly, in *Travelers*, the plaintiffs were commercial insurers, acting as fiduciaries of ERISA plans they administered. 514 U.S. at 651. In *DeBuono*, respondents were trustees of a fund which administered a benefit plan. 520 U.S. at 810.

Here, however, the target of the action is not the ERISA plan nor the administrator of the plan. As the government's brief concedes, without contest by petitioner's responsive supplemental brief, the petitioner's HMO "is not an ERISA plan; rather it is a service provider to the plan and to its participants and beneficiaries," (U.S. brief, p. 10; *see also*, U.S. brief, p. 9, asserting that the "Pennsylvania appellate courts incorrectly assumed that petitioner's HMO is identical to the employee benefit plan sponsored by Mrs. Pappas's employer.").

As a service provider, the HMO is neither the plan nor the plan administrator. The HMO's invocation of ERISA to shield itself from tort liability in this case, when there is no basis in the record to regard it as the employer's benefits plan or as the administrator of the employer's plan, is highly questionable. As your Honorable Court reiterated in *Travelers*, 514 U.S. at 656-657,

> in passing 514(a), Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans

> and employer conduct to the peculiarities of the law of each jurisdiction."

The tort action presented in this case, however, does not affect the plan or the plan administrator, nor does it involve a conflict with the federal government's directives regarding employee benefit plans.[3]

The question thus is whether your Honorable Court need intervene, in this particular case and at an early stage of its development, to decide whether a common law malpractice claim against a health care service provider is preempted by ERISA. Respondents contend the answer should be "no," because your Court's precedents demonstrate that Congress had no intent to remove such claims from their traditional roles in the states' interests, and because this case has not yet developed to the stage where your Honorable Court can exercise its limited jurisdiction over final state court decisions and provide definitive guidance to all lower courts.

As to whether the tort claim asserted against the HMO in this case has a "connection with" the ERISA plan, "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive," *Travelers*, 514 U.S. at 656.

Given the goal of ERISA to protect employee benefit plans and their administrators from the problems inherent in dealing with various state substantive and enforcement mandates for employee health care benefits, and given the government's

---

3. Notably absent from the government's brief and from the petitioner's filings is any specific prohibition either in ERISA or in the Department of Labor's implementing regulations against health care malpractice claims asserted against health care providers. Indeed, the government's brief concedes, without the slightest challenge from petitioner, that "When an HMO acts as a medical service provider, a number of courts have held — and we agree — that the HMO is subject to suit under state law for negligence in performing its medical duties" (U.S. brief, p. 10).

concession that HMO's can be sued under state law for their negligence as health care providers, one easily draws the conclusion from your Court's pronouncements in *Travelers* and in *DeBuono* that Congress did not intend to displace state malpractice law simply because the service provided can be linked to an ERISA plan. To paraphrase what the Court stated in *DeBuono*, 520 U.S. at 815, this is not a case in which the existence of a pension plan is a critical element of a state law cause of action, or one in which the state law contains provisions that expressly refer to ERISA or ERISA plans. A consideration of the actual operation of the state law leads to the conclusion that the malpractice claim asserted against petitioner's HMO is one of "myriad state laws" of general applicability that may impose some burdens on ERISA plans but nevertheless do not "relate to" them within the meaning of ERISA.

In *Travelers*, 514 U.S. at 661, your Court pointed out that the ERISA preemption clause cannot be read "to displace general health care regulation, which historically has been a matter of local concern". When Congress enacted ERISA, all of the states had traditionally allowed, and regulated to varying extents, health care malpractice claims. "And yet there is not so much as a hint in ERISA's legislative history or anywhere else that Congress intended to squelch these state efforts," *Travelers*, 514 U.S. at 665.[4]

Further consideration of the arguments advanced by the government and by the petitioners that Congress may have sought to displace state malpractice claims elicits an additional

4. The recent congressional activities regarding patient's rights alluded to in footnote 5 at pages 7-8 of the government's brief, do not necessarily indicate a sentiment that ERISA was meant to displace the type of claim at issue in this case. Those activities can also and perhaps more properly be viewed as seeking clarification of the limited preemption effected by ERISA and a correction of the lower court decisions that, unlike the decision of the Pennsylvania Supreme Court, have misinterpreted both the intent of Congress and the pronouncements of your Honorable Court.

distinction between this case and *Pilot Life* that the government's brief and the petitioner's filings fail to appreciate. When Congress entered the field of employee benefit plan regulation through the enactment of ERISA, the legislative choice was between diversity and uniformity, not between a contractual cause of action and concomitant relief and no cause of action or relief whatsoever. Congress gave ERISA participants and beneficiaries some cause of action and some relief akin to the cause of action and the relief asserted by the claimant in *Pilot Life*. Because the *Pilot Life* plaintiff retained the federal cause of action and remedies provided by ERISA with respect to the insurer's denial of benefits, the task of your Honorable Court in that case was to determine whether that cause of action and its remedies could be enlarged by the state cause of action and remedy.

However, in the context of a health care malpractice action against a service provider, such as this case, the Court's considerations are very different. The petitioner and the government urge the Court to rule that Congress usurped a traditional state field of law *without providing a parallel federal field of law* as it did with respect to the essentially contractual terms of ERISA.[5] Without a stronger indication of congressional intent beyond what petitioner and the government divine from the absence of a malpractice cause of action in ERISA, your Honorable Court should not assume that Congress intended to eradicate state health care malpractice actions against service providers such as the HMO in this case.

For these reasons, and those delineated in its Brief in Opposition, respondents respectfully suggest that your Honorable Court deny the petition for allowance of appeal, because the decision of the Pennsylvania Supreme Court is in accord with ERISA and with the controlling decisions of your Honorable Court.

---

5. That the congressional usurpation was limited to essentially contractual matters is evident in the remedial provisions of ERISA's section 502(a), as set forth in 29 U.S.C. § 1132(a).

The fears expressed by petitioner and by the government regarding the effect of a denial of the petition in this case are unfounded. The denial of a petition for a writ of certiorari does not represent a decision by your Court on the merits of the case or even on the merits of the issues for which review was sought. *Maryland v. Baltimore Radio Show, Inc.*, 338 U.S. 912, 917 (1950). Thus, a denial of the petition at this stage of the case's development would not stamp the imprimatur of your Honorable Court onto the decision of the Pennsylvania Supreme Court, nor would it compel other jurisdictions to follow the decision of that court.[6]

The denial of the petition at this stage of the case's development is particularly appropriate in light of the sketchy nature of the case and the real possibility that the petitioner will ultimately not be found liable. The decision of the Pennsylvania Supreme Court adjudged only the viability of the claim presented in the joinder complaint. That complaint presents only the barest of facts, and remains subject to amendment for the presentation of additional facts and further refined legal theories. Moreover, the Pennsylvania Supreme Court expressly refused to adjudge the merits of the claim as presented by the pleadings, and specifically noted that the petitioner might ultimately persuade the factfinder of its defenses or might be entitled to exoneration as the development of the case progressed (Petition, p. 13a, n.7).

In the alternative, but for different reasons, respondents join with the government in asking that your Honorable Court defer action on the petition until after it renders its decision in *Pegram*, and adds the request that the parties and the government be

---

6. As of January 27, 2000, Shepard's reported only one state appellate court case citing the decision of the Pennsylvania Supreme Court. In that case, *Hinterlong v. Baldwin*, 720 N.E.2d 315 (1999), the Appellate Court of Illinois, Second District, first made its own determination of the controlling principles and the issue, 720 N.E.2d at 320-321, before it mentioned the Pennsylvania Supreme Court's decision in a string citation, 720 N.E.2d at 322.

allowed to submit further briefs addressing *Pegram's* impact on this case.

Most evident in the government's brief in this case and in *Pegram* is the approach taken by the government to emphasize the action of the HMO, rather than to emphasize the status of the HMO and its relationship to the plan and to its administration. While the government's interest in securing federal authority over and national uniformity for the administration of employee health benefit plans under ERISA is unassailable, the government's approach is open to question. A comparison of the government's petition brief in this case with the merits brief that it filed in *Pegram* underscores the problem that the Court's decision in *Pegram* might resolve. In both cases, the government highlights the distinct existence of the ERISA plan and its administration from the HMOs. Despite the conclusion that ERISA does not or should not apply to an HMO that is neither the plan nor the administrator of the plan, the government's arguments proceed to characterize the nature of the HMOs' conduct. That point of analysis ultimately gets the government to where it wants to be in both cases, but it is one that appears to be inconsistent and largely unworkable.

In the instant case, the government's characterization of the HMO's action as simply a benefits determination allows the government to assert that the case is controlled by *Pilot Life* and that the HMO is subject to ERISA. In *Pegram*, on the other hand, the government stresses the independence of the HMO and its role as a medical provider to reach the conclusion that the HMO is not subject to ERISA. In the instant case, the government acknowledges that the decision made by the HMO may have had a medical treatment basis, but it concludes that the HMO's conduct should be regarded simply as a benefits determination. In *Pegram*, however, the government downplays the obvious benefits determinations made by the HMO doctors and concludes that those decisions cannot possibly be regarded as anything other than medical or purely business decisions.[7]

7. "The HMO and its parent entities are thus service providers to (Cont'd)

Consequently, *Pegram* provides an important platform for the Court to address the government's analysis in each case. The Court's decision in *Pegram* should provide additional clarity for further consideration in the context of this case. If the petition in this case is not denied, it makes sense to defer action on the petition until after the Court has rendered its decision in *Pegram* and to allow further briefing in light of the decision to be made in *Pegram*. On the one hand, the Court's acceptance or rejection of the government's analytical approach will inform the parties and the government of the correct approach to be taken. On the other hand, a delay of *Pegram*, as suggested by petitioner, for the briefing, argument, and decision in this case would unwarrantedly delay the normal operations of the Court, and unnecessarily postpone the guidance of the Court in cases similar to both the instant case and to *Pegram*.

CONCLUSION

For the foregoing reasons and those advanced in its prior briefs, respondents respectfully ask that your Honorable Court deny the petition for writ of certiorari. In the alternative, respondents respectfully ask that the Court defer action on the petition until after it renders its decision in *Pegram*, and that the parties and the government be allowed to submit further briefs addressing *Pegram's* impact on this case.

(Cont'd)
the plan; they are not themselves ERISA plans." Brief for the United States as Amicus Curiae, *Pegram v. Herdrich*, 1999 U.S. Briefs 1949, *10 (November 19, 1999). "[A]n HMO, in its role as provider of medical treatment to patients who are beneficiaries of ERISA plans, is not an ERISA fiduciary." *Id.* at *12. "The courts of appeals, however, have correctly held that state laws governing the practice of medicine by HMOs are not preempted by ERISA." *Id.* at *13.

Respectfully submitted,

CHARLES W. CRAVEN
Counsel of Record
STEPHEN A. RYAN
MARION H. GRIFFIN
MARSHALL, DENNEHEY,
WARNER, COLEMAN & GOGGIN
Attorneys for Respondents
1845 Walnut Street
Philadelphia, PA 19103
(215) 575-2600

(9)

No. 98-1836

Supreme Court, U.S.
FILED
JUN 14 2000
CLERK

In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition For A Writ Of Certiorari To The Pennsylvania Supreme Court

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO *PEGRAM* v. *HERDRICH*, NO. 98-1949 (JUNE 12, 2000)

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, D.C. 20006
(202) 263-3000

Counsel for Petitioner

7 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

CONCLUSION 4

TABLE OF AUTHORITIES

Page(s)

Cases

Pegram v. *Herdrich*, No. 98-1949 (June 12, 2000) . . *passim*

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO *PEGRAM* v. *HERDRICH*, NO. 98-1949 (JUNE 12, 2000)

Pursuant to Rule 15.8 of the Rules of this Court, Petitioner submits this brief in response to *Pegram* v. *Herdrich*, No. 98-1949 (June 12, 2000). As the government recognized in its Court-requested Brief for the United States as Amicus Curiae, "if the decision in *Pegram* does not fully dispose of the question presented in this case, the Court should grant plenary review in this case to ensure uniform interpretation of the extent to which ERISA beneficiaries may bring state-law negligence claims against HMOs." U.S. Br. 20; accord *id.* at 6-7 ("[B]oth the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here, suggest that, if *Pegram* does not clearly resolve this case, plenary review would be warranted.").[1] *Pegram* does not "fully dispose" of the question presented here, or "clearly resolve this case." Accordingly, plenary review is appropriate and certiorari should now be granted.

This case presents the question whether a state-law tort challenge to an HMO's benefits determination is preempted by ERISA. *Pegram*, by contrast, addresses whether a physician-owned HMO's decision about whether to order a particular treatment for a particular patient was subject to a claim for breach of an ERISA fiduciary duty.[2] The Court characterized the HMO's decision as a "mixed eligibility and treatment decision[ ]" (slip op. 17) and held that it was *not* subject to an ERISA claim for breach of fiduciary duty, because the physician-owners were not acting as ERISA fiduciaries.

---

[1] Our Supplemental Brief for Petitioner in Response to Brief for the United States as Amicus Curiae cited to the initial, typescript version of the government's brief. In this brief we cite to the final, printed version.

[2] Petitioner in this case is not a physician-owned HMO.

The government proffered two theories about how *Pegram* might affect this case. First, the government suggested that this Court might agree with the *Pegram* petitioners' argument that the "intended benefit" in an ERISA plan that provides medical benefits through an HMO is merely membership in the HMO. U.S. Br. 19. That rationale, the government argued, might provide an alternate basis for affirming the Pennsylvania Supreme Court's decision in this case. *Ibid.* Because "the conduct of the HMO in this case would not involve a claim for benefits under an ERISA plan (because it would not involve a question of membership in the HMO)," the government elaborated, "it is likely that the state-law negligence claim would therefore not be preempted." *Ibid.*

This Court did not, however, adopt the *Pegram* petitioners' argument that the "intended benefit" of the plan was merely membership in the HMO. As this Court recognized in *Pegram*, the HMO could be subject to a fiduciary duty under ERISA only if that duty arose in the course of the HMO's administration of the plan. Slip op. 10. If the Court had accepted the *Pegram* petitioners' argument, it would not have had to analyze whether the HMO's treatment decision concerning an HMO member could have constituted a breach of fiduciary duty. Because the Court did not accept the argument that the government says might have justified a non-preemption ruling in this case, *Pegram* does not in this respect justify either a grant/vacate/remand order or a denial of certiorari.

The government also suggested that the decision in *Pegram* might affect this case because the Court could "adopt[ ] the view" that "the 'administration' claims in *Pegram* are controlled by the principal that determinations regarding the benefits due under ERISA plans are governed by ERISA and its fiduciary duty standards," and "reaffirm[ ] the underlying principle" that "state-law claims based on the performance of such duties are preempted precisely because they *are* governed by ERISA." U.S. Br. 19 (emphasis in original). But the *Pegram* Court treated the relevant HMO actions in that case as "mixed

eligibility and treatment decisions" and rejected the argument that such claims are fiduciary in character. Slip op. 17-18, 20, 25. The Court did not analyze the preemption consequences that would flow from a determination that an HMO's actions *do* constitute benefits determinations subject to ERISA.[3] In the present case, however,

> the Pennsylvania Supreme Court did not suggest that petitioner acted other than in its role as plan administrator, or, indeed, that petitioner exercised any medical judgment at all. Rather, the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, *made a benefit determination.*

U.S. Br. 12 (emphasis added). Thus, this case is different from *Pegram* because it undisputedly involved a pure benefits determination, and because the issue it raises — preemption — was not reached, even in dicta, in *Pegram.*

Because of these differences, an order granting certiorari, vacating, and remanding for further consideration in light of *Pegram* would almost certainly leave the Supreme Court of Pennsylvania scratching its (metaphorical) head about what relevant insights it is supposed to have gleaned from *Pegram*, and in all likelihood would result in a mere reaffirmance of the erroneous (U.S. Br. 7-14) and certworthy (*id.* at 14-18) decision that the state court has already reached. And nothing in *Pegram* could even conceivably justify a denial of certiorari — indeed, all of respondents' arguments for denying certiorari, which have nothing to do with *Pegram*, were considered and rejected when this Court opted to ask for the Solicitor General's views and then hold the case. The only reasonable course remaining is the

---

[3] The Court's only mention of preemption was at the end of the opinion, where the Court observed that applying a *malpractice* standard under ERISA — a course that the Court rejected — "would seem to be a prescription for preemption of state malpractice law." Slip op. 24.

one suggested by the Solicitor General last December: now that *Pegram* has been decided and does not "fully dispose of the question presented in this case" (*id.* at 20), the Court should grant certiorari for full briefing and argument on the merits.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

BURT M. RUBLIN
BALLARD SPAHR ANDREWS & INGERSOLL, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

ROY T. ENGLERT, JR.
Counsel of Record
SHARON SWINGLE
MAYER, BROWN & PLATT
1909 K Street, N.W.
Washington, DC 20006
(202) 263-3000

JUNE 2000